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The Meeting of Cultured Worlds: Professional Identification in Indian Postgraduate Physiotherapy Students

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Dedication

This thesis is dedicated to the physiotherapists of India.

Abstract

This research aims to provide a more detailed understanding of transnational professional education. In doing so it develops current critical perspectives of physiotherapy, focussing on issues of internationalisation. The impetus for the research was my concern for the relevance of a Masters' degree for Indian physiotherapists studying at an English university when their future working lives lie in India.

I interviewed six Indian students during the dissertation phase of their study. The research methodology is formed using a bricolage approach, one that synthesises aspects of phenomenological (Wertz, 2011) and constructivist grounded theory (Charmaz, 2014). Since becoming a professional is synonymous with developing an 'identity', I interpret participant professional identification constructions and working cultures in different national contexts using a theoretical perspective drawn from Holland et al., (2001). This provides an ethnographic understanding of participants' cultural practices and illuminates the cultured worlds of both physiotherapy practice and its teaching in the course as well as their agency within different national contexts.

I show professional work to be suffused with meanings and reveal the interplay of cultural and symbolic capital between patient and physiotherapist (Bourdieu 1986). Different professional, cultural practices can be seen to hold similar meanings and the centrality of the engagement between patient and therapist is exposed. Wider practice contexts (structural, social and political issues) shape the power relations concomitant to physiotherapy, and thereby strongly influence its practice in different locations.

I also expose a hegemonic discourse within course teaching, expressed in participants' narratives of rejection of previous Indian practice, notwithstanding their recognition of the limitations within an Indian context of the practice taught. Critical race theory suggests this forms an example of an oppressive pedagogy (Ladson-Billings and Tate IV, 1995). Although participants describe an increase in self-confidence from studying abroad, paradoxically, I argue that some loss of confidence is likely to result from these unintentional positionings. Further I contend that part of the ethical responsibility of teaching is that it is respectful of different perspectives (Carroll and Ryan 2007). This is particularly important when working with international students, where the student's home context may be difficult for tutors to comprehend.

Acknowledgements

I wish to thank everyone who has contributed to shaping this thesis and supporting its development from initial concept to final presentation. Many people have helped me to achieve a view on identifications, practice and cultural worlds, but most importantly they have helped me enjoy the journey towards these new perspectives.

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Candidate's Statement

This to certify that:

I. the thesis has not previously been submitted for a degree or comparable academic award,

II. the thesis comprises only my original work towards an Ed D,

III. due acknowledgement has been made in the text to all other material used,

IV. The thesis is less than 62,000 words in length exclusive of reference lists, diagrams and appendices.

_____

Hazel Horobin

10th January 2016

Publications and Conferences

Publications

Horobin, H. & Thom, V. (2015). Starting with Transitions: Internationalisation for a Post Graduate Physiotherapy Course, Green W., Whitsed C., Eds. In Critical perspectives on internationalizing the curriculum in disciplines: Reflective narrative accounts from business, education and health, Dordrecht, Netherlands, Sense Publishers, 249-260.

Conference papers

June 25th - 26th (2015). Subtle Stereotyping of Other in Transnational Physiotherapy Education. The Centre for Racial Equality in Scotland and the University of Edinburgh 2nd International Conference 2015: The stubborn persistence of racism: confronting racial inequality through education and action, John MacIntyre Conference Centre, University of Edinburgh.

April 2nd – 4th (2014). Professional Identity Development in Physiotherapy: From India to the UK. Transcultural Identity Constructions in a Changing World, Dalarna University, Sweden.

Glossary of Terms

AHP – Allied Health Profession(al)s. Health care professions that assess and treat independently within a limited framework of specialist health care practice, that are managed to a greater or lesser degree by medical staff depending on the legal status of the AHP in that country.

Course – in the text this generally refers to the Masters in Science (MSc. or simply Masters) in Physiotherapy delivered at the central UK located university. It is also sometimes referred to as the programme.

CPD – Continuing Professional Development. This refers to the process of tracking and documenting the skills, knowledge and experience that are gained formally and informally at work and after initial education and training.

CSP – Chartered Society of Physiotherapy, the professional body of UK physiotherapy practitioners.

Definitive document – the documentation that defines the teaching and learning of academic programmes, it confirms student progression through modular courses and outlines the pedagogy, staffing and resources that support course teaching, learning and assessment.

Electrotherapy – the umbrella term for the variety of electro-magnetic wave producing machines that are used as forms of treatment. These techniques are also referred to by the participants as modalities.

First contact care – the legal framework which permits AHPs to offer patients their first element of care independently without recourse to a physician.

HCPC – Health Care Professions Council, the registering body for physiotherapists in the UK.

HE(I) – Higher Education(Institution) or indicating university level education

IAP – Indian Association of Physiotherapy, the professional body of Indian physiotherapy practitioners.

Maitland technique(s) – the most common form of manual therapy (see manual therapy below) in the UK are from the Maitland school of thought. The concept is named after its founder, Geoffrey Maitland, who is seen as a pioneer of musculoskeletal physiotherapy. These are generally a series of small, oscillatory, passive movement techniques of a 'nudging' type, undertaken usually by the hands of the therapist on the patient, but can also be through any part of the limbs. They are achieved using the strength of the therapists' arms or the weight of their body to generate movements not possible as individual movements by the patient. They aim to improve movement and reduce pain.

Manual therapy – refers to the performance of movements on joints by therapists. Participants also referred to these techniques as 'handling', 'mobilising' or 'mobilisations', and 'hands on'.

Masters level – in the UK this refers to post undergraduate, post professional qualification level study and for physiotherapy this is almost exclusively for an Masters in Science (MSc) award.

McKenzie technique – an approach to musculoskeletal therapy that is based on exercise, repeated movements and sustained positions for the patient, rather than manual therapy.

Modalities – see electrotherapy.

MSK – musculoskeletal practice, work relating to outpatient physiotherapy practice, frequently involving injury or disease within soft tissues or joints.

Patient(s) – the end user of physiotherapy services, also called 'service user(s)' at some points in the text.

Physical therapist – the term for the equivalent profession to physiotherapy in the USA.

Programme – course (see 'course' above).

PSW visa – Post study work visa, available until April 2012 which permitted students who had come to the UK to study to stay on to work in the UK for 2 years following graduation.

Service User – see 'patient' above.

1 Chapter 1. Introduction to Thesis

In Chapter One I give an overview of the contextual and personal rationale for undertaking this research and outline the structure of the thesis. As the study relates to the learning of Indian physiotherapists on a course based in England. I explore the background contexts to the research, the profession of physiotherapy and the globalising processes that facilitate the travel of Indian physiotherapists to the UK to pursue post graduate qualifications. I also consider my influence as a researcher situated inside the project.

1.1 Introduction

I taught international physiotherapy students at Masters level between 2005 and 2014. During this time cohorts ranged from 20-100 and approximately 90% of the students were Indian nationals and studied an MSc Physiotherapy programme offered at a university in central England. The course was of 18 months duration, one year academic delivery of mainly compulsory modules about research and evidence based practice, treatment techniques and the context of health care in England, and six months undertaking a theoretical dissertation. Some clinical specialisation was possible and most students chose neurological or musculoskeletal practice. The content was largely theoretical with limited availability of clinical placements.

From previous experience of working abroad I knew that the former, home practices of these Indian physiotherapists were likely to be very different from those found in England. And indeed, while teaching the course, I found myself in classrooms with people for whom English assumptions about what it means to be a physiotherapist were new and challenging. As my appreciation of the contextualised nature of learning developed (Lave & Wenger, 1991), I wondered about the impact of the course on these students. My research emerged from my interests both as a physiotherapist and as an educationalist: as a physiotherapist about how students resolved the tensions presented through the widely varying approaches to therapy practice used in different locations and as an educationalist about what could be learnt about diversity in

learning and teaching environments. Thus my research is pertinent to both practising physiotherapists as well as Higher Education (HE) educators working in cross national[1] contexts.

My original contribution to knowledge is an understanding of the meanings generated by Indian physiotherapists from their learning as students on this professional, England delivered, post graduate programme in physiotherapy. The research involved interviewing six Indian physiotherapy students twice during the final phase of their study programme as they undertook their dissertations. Our discussions implicitly and explicitly contain the meanings they hold about physiotherapy practice (Seidman, 2012), including the ways the course influenced them.

Like Dall'Alba and Barnacle (2007), I consider learning to be a process of becoming, with who we are being represented by our identities. Jenkins (2014) suggests that our identities are contained within the stories we tell about ourselves (Jenkins, 2014) and in this way our narratives are imbued with representations of our sense of self. I adopt the particular view of identities (or identifications) generated by Holland et al. (2001), that they are not an entirely personal construction, but are imbued with the structural contexts that shape and form what is possible, permissible and desirable (Babad, Birnbaum, & Benne, 1983). I define terms and explore the structural and cultural aspects relative to the contexts contained within the research arena in more detail in Chapter Two. This thesis as a whole explains and reports on the qualitative research project undertaken to discover participants' professional identifications. Through exploring individual identifications and seeing these as reflecting the culture within which they are formed, I have been able to view the structural issues relating to the participants' physiotherapy practices (Holland et al., 2001). As a consequence, the participant's professional identifications can be seen to relate to both working and learning cultures (Gee, 2002).

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[1] I use the term 'cross-national' rather than 'transnational' to represent the plurality of nationalities in the UK classroom because transnational has a specific meaning in HE relating to out of country provision of education. I also avoid the terms 'trans-cultural' and 'cross-cultural' given the difficulties of defining 'culture' to be outlined later.

Recognising that physiotherapy practices are constructed in socio-cultural arenas (Denzin & Lincoln, 2011), I used an interpretivist, qualitative research methodology that developed from phenomenology and was influenced by both grounded theory and ethnography. I distilled the similarities or patterns in our conversations to generate perspectives on participants' professional identifications (Edwards & Usher, 2008). In my interpretations and thinking around identifications I explored participants' thoughts - in all their complexity, subjectivity and contradiction - about the way they worked. Immersing myself in the data I recognised the culturally and socially prescribed principles of their (and our) contexts which define the cultural worlds of both professional and pedagogic practice and expose the power relationships underpinning them. In this way I was able to expose the different structural issues, exerted through Indian and English[2], social and global contexts which establish working arenas and form cultured worlds of practice. Viewing these relationships and contexts through a critical lens, the impact of teaching relationships is exposed and explored with a view to developing more inclusive pedagogic practices.

As a precursor to the more detailed discussion of practice identifications that follows in the research analysis (Chapters Five and Six), I offer a brief synopsis here of physiotherapy as a profession and the migratory impulses to which it is subject. These form the background to considerations of the research.

1.2 Physiotherapy

Physiotherapy began as a rehabilitation specialism of nursing in the UK in the early 1900s, spread worldwide and now has a global presence, being known as either physiotherapy or physical therapy. It promotes patient[3] functional ability and quality of life, essentially incorporating non-pharmaceutical approaches to enhance recovery and healing. Treatments involve a variety of physical agents such as exercise; movements, massage and other handling techniques;

[2] Since devolution in the late 1990s health care practices have diverged between England, Wales, Scotland and Northern Ireland, so health care practices are discussed specifically in relation to England where the course was based.

[3] The use of the term "patient" is somewhat contested because of its implied paternalism (McGuire-Snieckus, McCabe, & Priebe, 2003) but, since this is the term exclusively used by the participants in the study, I have chosen to remain consistent with their terminology until my analysis in Chapter 6.

mechanical forces; adaptive devices; heat and other electromagnetic devices; all utilised with the aim of restoring wellbeing. The Chartered Society of Physiotherapy (CSP), the physiotherapist's professional body describes physiotherapy as:

> *'..physical approaches to promote, maintain and restore physical, psychological and social well-being, taking account of variations in health status. Physiotherapy is science-based, committed to extending, applying, evaluating and reviewing the evidence that underpins and informs its practice and delivery. The exercise of clinical judgement and informed interpretation is at its core.'* (CSP, 2014)

Commonly, the term 'health worker' refers to doctors and nurses (Dumont & Zurn, 2007), but physiotherapy is the next largest health care profession (Higgs, Refshauge, & Ellis, 2001). There exists a strong relationship between professionalism and education:

> *'A profession is a body whose membership is accorded after a long effective training under the control of experts in a university context, which guarantees the quality and effectiveness of members' work.'* (Higgs & Hunt, 1999, p. 34)

Yet we know very little about physiotherapy professionalism or education. Physiotherapy lies deep within UK health services and has a fascinating, but as yet little explored, micro-culture of physical enactment and performance. Social science research within the profession is relatively rare and what qualitative research exists tends to be theoretically weak (Lipponen & Kumpulainen, 2011). This might be because physiotherapy remains a relatively new profession which only recently became recognised as a degree status profession (Boyce, 2006) and so has had relatively little time to define or consider itself. However Occupational Therapy, a related allied health profession and which emerged at around the same time, has developed a strong research discourse using qualitative methodologies (Kielhofner, 2009) which undermines this argument.

Perhaps more relevant is the dominant research discourse within physiotherapy which is firmly based on a positivist tradition, sometimes seen as a legacy from

its historical link to medicine (Boyce, 2006). The dominance of scientific constructs, seen in practice through the promotion of the principle of 'evidence based practice', has perhaps limited the profession's capacity to consider itself and its professional position to any great extent. Globalisation processes have generated diversity within the client group and resulted in significant increases in the numbers of physiotherapists who have qualified in other parts of the world migrating to the UK. These factors and increased exposure to various practices through global communications have highlighted the need for greater cultural awareness (Norris & Allotey, 2008). It has certainly acted as a motivation for me to consider more deeply how and why physiotherapy practice appears to vary from country to country. It is therefore appropriate to explore the reasons for physiotherapist migration[4], before returning to professional issues.

1.3 The Migration of Indian Physiotherapists to the UK

When viewing immigration statistics it is common to analyse the 'push and pull' factors behind trends, the 'push' describing those features of the home country that encourage movement outwards and 'pull' being those aspects of the new location that encourage immigration (Arango, 2000). Here I expose some of the pertinent factors which help inform the background context for students who enrol onto the MSc Physiotherapy programme. Doing so contextualises the presence of Indian therapists in the UK, and exposes some of the structural issues that will be seen later, as important in shaping individual identifications. Such an overview can only offer a general indication of complex and distinct situations, as there is no single, uniform cause for health care worker migration.

One significant factor bringing Indian physiotherapists to the UK is undoubtedly economic forces, as they can apply for positions in health services which offer much better pay and work conditions than are obtainable in their home countries (Buchan, 2005; Kline, 2003). As increasing numbers of qualified therapists in India are pushed from their home country due to a paucity of available jobs, they are equally pulled towards better resourced countries which

[4] When referring to migration in this context I signify temporary migration of students rather than the more usual use of the term meaning permanent migration.

are experiencing a shortage of health care professionals (Stilwell et al., 2004). Another significant attraction to the UK from India arises from historic links between the two countries. The UK controlled India, first economically (through command of sea trading) and then politically for more than 300 years, between around 1600 and 1947. By 1820 the UK held political dominance over most of India as part of the British Empire. It is beyond the scope of this chapter to discuss this colonial history in detail and there are many other sources relating to this information (Ferguson, 2008). However, among the many historical social influences of this colonial intervention are both the widespread speaking of English in India and the high prestige associated with UK degrees (Pietsch, 2011). Furthermore, social networks exert their influence across vast distances and India is the commonest country of birth for foreign-born people living in the UK (Rienzo & Vargas-Silva, 2013). Relations and friends from earlier migrations can generate extended support connections that are helpful as students undergo the psychological challenge of moving country and continent, and the presence of these networks may add to the attraction of studying in the UK. These factors may, in part, explain the popularity of the MSc course amongst Indian nationals.

Developments in modern global travel and communication systems obviously support migration. The drive for the migration of health workers from less to better resourced countries has increased as, between 2000 and 2010, nearly all the country members of the Organisation for Economic Co-operation and Development (OECD), which includes the UK, saw a rise in the number of international health care workers migrating in (Dumont, Spielvogel, & Widmaier, 2010). The steady level of health spending in more affluent countries, even despite the recent economic downturn, demonstrates the resilience of this as a migratory lure (*ibid*). Economic advances in the countries of emigration have also, paradoxically, encouraged migratory impetus, as this stimulates improvements in both school and professional education, which has facilitated recognition and accreditation of qualifications gained in the home country (Stilwell et al., 2004). For physiotherapists qualifying in India, it means that their undergraduate studies are seen in the UK as a suitable grounding for post graduate study on a UK course.

The net impact of these push and pull factors is that physiotherapists form part of a global movement of health professionals (Young et al., 2010). Evidence of this professional diaspora is shown by the number of Indian nationals who have successfully applied for registration as physiotherapists with the Health Care Professions Council (HCPC, the health, psychological and social work regulator for the UK) from just a handful at the start of the millennium to 1,586 in 2011 (HCPC, 2011).

1.3.1 Employment and Educational Consequences of Migration

Students who come from overseas to study in the UK are estimated to be worth 8 billion pounds to the UK economy and there is wide acceptance that their presence underpins HE finances. Not only are international students actively sought as a means of offsetting the constraints of a reducing internal UK income, but they are also seen as supporting the national economy. In the past, few of those incoming students were health care practitioners, but given the health care situation already outlined, global economic changes have led to increases in international health care worker migration in recent years (Clark, Stewart, & Clark, 2006). Variations in health care systems and traditions between different countries have resulted in a demand for health education from these migrating health workers.

In the UK most physiotherapy posts are contained within the National Health Service (NHS) which is the largest employer of physiotherapists[5]. For work in the NHS candidates are normally required to have some UK experience of working (equivalent at least to that provided during undergraduate education) as evidence of capability. Overseas trained physiotherapists are then at a disadvantage in the UK job market compared to their local counterparts for qualified positions since their lack of experience acts as a barrier to accessing employment. However 'experience' can be demonstrated though study at a

[5] It is not easy to find employment data relating to physiotherapists. This appears to be a rapidly changing arena as the current Conservative government continues with health care reform. However as an indication there are approximately 2,450 physiotherapists registered to the 'Independent Healthcare' network, which is the private practice focused occupational and special interest group forum for the Chartered Society of Physiotherapists. This is compared to more than 51,000 physiotherapists and associates registered with the CSP overall (CSP, 2015).

level higher than the degree requirement for professional entry. In this way, a Masters level course presents students with a period of 'adaptation' to facilitate and badge (through qualifications) their engagement with issues of professional regulation as well as cultural change (Walt, 1998). So the demand for such a programme of education rose as immigrants sought to adjust to the variations in health care systems (*ibid*).

During the last decade the university at which I taught, like many other UK Higher Education Institutions (HEIs), had a policy of active recruitment of international students as a means of offsetting the constraints of a reducing UK income (Easton, 2010; Shiel & McKenzie, 2008). Before this, the university Faculty which educated health care professionals depended almost exclusively on NHS contracts for health subjects, contracts which were under constant review. In order to provide some diversification of income stream, the MSc in Physiotherapy course was offered from 2005, and was designed to attract predominantly international students. Growth in this course was facilitated by the then Labour government Tier 1 Post Study Work (PSW) Visa scheme that permitted graduates to remain in the UK for two years after graduation. This allowed alumni an extended period to learn new culturally located ways of being, in order to progress from the end of the academic course into professional work within the UK. The PSW visa ended, however, in April 2012 and resulted in my research taking place in something of a transition period, where work opportunities for graduates were shifting away from the UK and back to the students' home country, or other better resourced countries.

1.3.2 The Migratory Experience

The life and experiences of Indian physiotherapists studying in the UK give a real and 'lived' dimension to the global phenomenon of health professional migration. This migration can be at a high cost. Physiotherapists travelling from overseas to study in the UK have their identifications challenged by geographical, educational, cultural, emotional and linguistic relocation (Simpson, Sturges, & Weight, 2009) representing a human cost to migration. Students face the practical problems of temporary homelessness and have to

adjust to new conditions and encounters with strangers. In many senses they are liminal, located between physical geographical as well as cultural boundaries – suspended, for a time, between social structures (Rutherford, 1990; Turner, 1993). It is hardly surprising, then, how much of the literature on overseas students has focussed on their distress as they enter UK Universities to study (Austin, 2007). My experience has been that Indian graduates go on to encounter difficulties in making the transition in professional practice from India to the UK. Challenges to professional working have been recognised as an issue for migrating professionals: Austin (2007, p. 239) describes immigrant pharmacists as suffering a 'double culture shock' as they struggle to adjust to the new cultured worlds of both social and professional life.

Due to the changes in visa terms outlined above many students who had perhaps originally sought out the course in order to be able to stay in the UK to work knew that they would now probably have to return to India. In this context of uncertainty and, for some, disappointment, the issues relating to meaning making from the programme emerged even more strongly than before. My students and thus, my potential research participants, were vulnerable, positioned in the research context as stressed about their past and present and uncertain of their future.

The literature relating to the impact of mixed cultural world study seems uncertain (Friedman & Antal, 2005). There is the suggestion that students take a hybrid approach when it comes to applying their study, combining home and host practices (Grimshaw & Sears, 2008). However, in contrast to this rather hopeful consequence of cross-national education, it should be noted that these accounts have not considered the impact of historical connections of the kind that exist between India and the UK, a history redolent with cultural supremacy and domination over centuries. Having outlined the structural vulnerabilities of participants, the challenge for me as researcher is how to address them and I consider this next.

1.4 Personal Contextual Narrative

I have already outlined that my research has been inspired both through my recognition of the struggle that internationally qualified physiotherapists experience to gain work in the UK (section 1.3.2) and the lack of information or understanding around meaning making in the classroom. The next consideration is how it should be undertaken. A positivist approach to the role of researcher would result in me undertaking this work as an objective and authoritative observer, a 'distant expert' as Charmaz suggests (2000, p. 513). In making participants 'other', I simultaneously position myself as an authority and place myself at the centre of the research. So rather than addressing issues of marginalisation and prejudice, I become at risk of merely reproducing the same power dynamics that sustains a privileged elite (Hayes & Oppenheim, 1997). I recognise that my communication with the participants is imbued with the socially and historically derived nature of the identities we exert on each other. In this context there is no escape from the double hermeneutic of mutual influence (Giddens, 1984). The participants and I are different, they are students on a course where I am a tutor, we are from different countries, have different life histories and experiences of working, but through our interactions we enact our socio-cultural identifications, making me a part of the research (Edwards & Usher, 2008), rather than standing as an external observer of it (Guba & Lincoln, 1994).

My immersion makes researching in this arena problematic because of the intractable nature of power relationships and the differences between me and the students. The causes of this are varied: my age, my role as tutor and also the power discourses evident between less well-resourced countries[6] and the UK, particularly as India had also been a colony of the UK. It is impossible for either the participants or me to be free from these relationships that shape our engagements in the research (Carspecken, 1996). Grappling with how to manage and view these issues formed a large part of my thinking throughout the research process.

[6] Previous literature commonly refers to 'developed' and 'under developed' countries. This is a subjective categorisation and I prefer the more factual terminology of 'well resourced' and 'less well resourced' locations.

Since my researcher narrative is also shared within the same cultural world of the course, it is therefore necessary both to explore these issues in myself and my presence in the research (Pillow, 2003). Through this I aim to demonstrate not only my understanding of these concepts but also my rationale for the research, the methodology and interpretation of the data. In recognising my own background context, the experiences and attitudes that shape my engagement with and during the research process and the conclusions I have drawn, I seek to offer readers both an attempt at transparency and an opportunity to interpret my thinking for themselves.

1.4.1 My Educational and Professional Identifications

I find points of connection with the Indian M level students through both their educational and professional identifications and, in part, exploring their experiences has been a mechanism through which I have been able to explore my own. At first consideration this seems unlikely: how can a middle-class, middle-aged academic from England identify with young, mixed caste Indians? But implicit within identifications are the structural conditions that contextualise people's lives, and through perceiving these, similarities emerge. The following exploration of critical incidents from my life highlights some of my identifications within the constructs of my cultural world. I then suggest how these impact on my research.

I was born and brought up in a small town in the Midlands in the 1960s. After a seemingly successful junior school life, I failed my eleven-plus and was sent to a secondary modern school. This was a difficult time for me. I remember being aghast by careers classes featuring a cartoon character 'Neville Sponge', the mastic asphalt spreader, who implied that we (the boys at least: non-grammar school girls were not expected to have careers) should/would become manual labourers[7]. With hindsight, the low expectation expressed by teachers was redolent of class based stereotyping. Due to the structure of the English education system at the time, had I remained where I was, I would have been

[7] I am not alone in remembering Neville Sponge - see also http://www.theanswerbank.co.uk/Jobs-and-Education/Question835938.html and a copy of his careers advice can be found in The National Archive.

denied access to the education required to progress to professional training and the formation of my current professional identification. It was a mixture of luck, good grades and some supportive school teachers that meant I was able escape the structural limitations imposed by secondary modern schooling and transfer to a grammar school. Only there did I have the opportunity to take 'O' and 'A' levels, allowing me to continue with education and become part of the wholesale professionalisation of many white collar workers that took place in the latter quarter of the last century in the UK (Nancarrow & Borthwick, 2005). This clear structural disadvantage was in part addressed by the dismantling of the grammar school system which happened whilst I was at school, but not sufficiently early enough to impact on my education.

The lack of access to university education for the majority of people in the UK throughout most of the 20th century meant that no one in my close family had been to university or held a professional job, and having had no previous exposure to it in my family or school life, professional working was something I found hard to grasp. Learning a profession is synonymous with acquiring an 'identity' (Aikenhead & Jegede, 1999) and I recognise now my profound crisis of identification at that time. Not only did I lack confidence from my experiences of school, but I simply did not understand what was expected of me. I went to a physiotherapy school run with military style authoritarianism and the transition from school and home life was stark and disorientating. I think only a poverty of imagination and a determined obduracy kept me there.

Following a decade of working in Birmingham hospitals as a physiotherapist, I joined a humanitarian, development organisation and spent four years in the Amazon region of Brazil as a physiotherapist on a leprosy control programme. During this time I experienced the personal struggle that is created by trying to understand life and work in another country. But after 4 years of immersion I returned to England, mainly because I was unable to register as a physiotherapist there (consequent to protected professional registration). Paradoxically the sojourn in Brazil and the re-configuring of my physiotherapy role to function in a new environment strengthened my sense of being a physiotherapist, even whilst it weakened my sense of 'Britishness'. These

experiences not only further demonstrate the influence of the structural, but also show that my national and professional identifications are actually fluid constructs - concepts that might have been considered 'static'.

My national identification also relates to my history. As a child I do not remember meeting many people that came from beyond my home town. Affordable package tour travel was not yet widely available and I did not go abroad on holiday, nor did anyone else that I knew. I can remember the first brown skinned person I ever saw at age eleven, when a family of Ugandan Asians, ejected during Idi Amin's rule, arrived in my school. On leaving school I went to Birmingham to study as a physiotherapist and found that I was ill equipped to engage with the many more immigrants, mostly Asian, I met in hospital settings. I felt frustrated by patients who could only describe symptoms as 'plenty pain' and who responded to nothing I did or said.

The identification adaptations and the personal struggle I experienced during my school life, my professional education and later working, culminating in the work I did in Brazil, have profoundly contributed to my attachment to my research. There is an emotional element to this research context: I have been 'other'; I have known identification confusion and experienced 'culture shock'; I have resisted and ultimately aligned myself very strongly with ways of being and living that are different to those I was born into. So whilst the students and I come from very different cultural worlds I am alert to their transition experiences. This not only forms for me a potent source of identification with them but also, in my view, enhances my credibility within the research.

1.4.2 My Stance towards Indian Students

When I studied for my Physiotherapy Diploma communication skills were not included as part of the curriculum, let alone engaging with diversity. As I entered the world of work on graduating, professional models of working I had gained in my course left me unprepared to connect constructively with the diversity of people in inner city Birmingham. Daily I was challenged by people who were superficially at least very different from me in terms of appearance, beliefs and

customs (Kai et al., 2007). I did make some attempts to understand those I was working with; trying to understand their language, traditions etc. For example, I had translated a text for orthopaedic patients that explained exercises in Hindi and Urdu, but my attempts were unsuccessful since they were framed by my own points of reference and I failed to realise the lack of literacy in many of those patients I was working with. My frustration then was directed towards the patients and looking back, I can see that I normalised my own way of life (Osborne, 1996).

Having worked in inner city Birmingham and in the Amazon, to then be called upon to educate students from a less well-resourced country, who were taking an expensive course that was designed to help them leave their country of origin challenged my identification with issues of social justice and sense of cultural relativism (Geertz, 1973). I empathised with the students on the MSc course, which appeared to pay little attention to, or interest in, existing constructs of treatment from the students' undergraduate study. But part of my research journey has been for me to explore the boundaries of empathy, because I now see that my experience is not necessarily theirs and during the research I have needed to be consciously aware of not projecting my own feelings into my research work such that it distorts the meanings that I draw from it. I discuss this further in Chapter Three (section 3.3)

Equally it should be noted that my position of empathy and emotional engagement expressed above also existed in some tension with my role within the university. I was not only a tutor of physiotherapists, but also a Principal Lecturer with responsibility for 'International Student Experience' within the business team. I acted as a staff and organisational developer with a responsibility for supporting international student recruitment and the welcome and support of international students joining the Faculty of Health[8]. I arranged staff/student parties, cultural adjustment events, English language support, buddying and employability activities, and generally had a high presence within their programme of study, particularly during induction. My identification as

[8] Not its real name.

someone empathetic to a student's struggle to conform, and as a co-worker in a less well-resourced environment, whilst also tasked with encouraging more to enrol, challenges the veracity of my stance as empathetic.

Also in relation to my educational role with the course, I was module leader for a compulsory module about professionalism. In this module we addressed ideas around working and professionalism as they are constructed in England and the UK more widely. The assessment contained an aspect of peer support, where students from previous cohorts were encouraged to engage with those in the module, and through this peer mentoring service, I had extended contact with some volunteering students, supporting them as they supported others. It was in this module that issues of different ways of working were addressed and where my awareness of the cultured nature of practice developed.

The discomfort and tension within my own identification in this regard, as empathetic and collaborative with Indian students (or not), provided a strong motivation to explore the meaning of the course to students. I was anxious to establish that the programme was helpful to them, that they had gained something of value – rather than paying for something that was no use at best, or a perpetuation of colonial oppression at worst. Identification constructs have helped me see the manner in which Indian physiotherapists have understood new ways of being and different practices, as well as their views on the world(s) in which they and we exist. They have formed a useful way of understanding the issues that 'people care about and care for what is going on around them' (Holland et al., 2001, p. 5). The participants express their development eloquently and gain a great deal of 'learning' from the programme, but this learning differs from my expectations. They reveal the structural limits that contain everyone and in analysing those limits I now also recognise the structural limits that contain me. This understanding has mediated and matured my empathy for students as well as those who teach them.

Just as my cultural experiences of physiotherapy influence my study of cultural worlds, my thinking about the teaching of physiotherapy includes the learned

social behaviours of tutors. I have an insider's appreciation of the systems, rules and symbols of interpretation and engagement for understanding this cultural context (Goodenough, 2003). These issues establish the foundation for communication of meanings and the ways by which these meanings are reproduced and transmitted (Hoggart, 1957; Lyotard, 1984). The very specific professional requirements of practice in different locations (Zurn, Dal Poz, Stilwell, & Adams, 2004) raised questions for me around what exactly the impact of the MSc programme was on Indian students. My familiarity with Indian and English practice and the course permitted me to see the alignment of identifications, and in that way generate some thinking about the nature of the cultural worlds constructed both by the course and the participants. I now explore these two areas of practice and teaching in relation to the research aims.

1.5 Research Aims

My approach to my work in the context of my life experiences, combined with the arrival of Indian physiotherapists in the UK, has brought together within an educational setting, issues of professional identification and cultural worlds of practice for me and the participants. This co-incidence and the emotional resonance it generated has been the source of my research motivation and shaped my aims. After an initial pilot study where I interviewed three alumni from the course who were working in England, I interviewed six volunteer participants from the two 2013 admissions cohorts of the MSc course. The research aims both narrowed and deepened as I progressed with the interviewing, stimulating several key revisions to arrive at my final research premise as demonstrated in the aims. Charmaz suggests that this kind of development is not unusual for projects involving a grounded theory type approach (Charmaz, 2014a).

My initial purpose was to establish what meanings Indian physiotherapists generate from the teaching and learning on an MSc Physiotherapy programme at an English university. In the quest for 'what learning means', I 'discovered' identity as a construct, but in finding identity I realised that a focus on individual

psychological constructs would be highly limiting and potentially distorting. I needed to also recognise the external structures that shaped and contextualised the course. In exploring their cultured worlds, I also began to see my own structural constraints as well as those in the world we shared – that of the course. This approach meant that I not only perceived their identifications, but also those that I exerted (through the course). The net effect on my aims was to define them more specifically, but also see them more broadly. So ultimately the original research aims became defined and expanded to form the following exploration of the structural context and the individual agency in the cultural worlds of physiotherapy (Holland et al., 2001):

I. What are the professional identifications expressed by Indian physiotherapists at the end of an English programme of study? Having identified these, what can be said about the structural factors that shape practice approaches within different locations? How do these identifications demonstrate the limits and expressions of agency in the cultural worlds of physiotherapy practice?
II. What can then be said about the cultured world of physiotherapy practice and teaching practice from the identifications outlined?

What emerged are variations in practice identifications between differently cultured locations. These practices are shaped by discernible structural influences rather than solely national standpoints. Students demonstrate a flexible approach to practice within the varying structural demands of different locations which supersede national differences to generate a unified view of physiotherapy. During analysis it becomes clear that taught practices dominate the participants' ideas of practice. An ethical response to this demands an analysis of the cultured world of the programme, again with structural aspects at its heart. From this I explore the lessons tutors and organisations might learn, not only in relation to cross-national teaching, but also when engaging with the potential power differential between students and educators in the academic arena.

1.5.1 Research Limits

Clearly the courses undertaken by overseas qualified health professionals in the UK cannot be isolated from the wider context of labour migration towards better resourced countries (Castles, 2000). This research does not focus on the complex ethical issues that this migration generates, whereby a better resourced country gains the most highly educated and needed workers from another, poorer country since these aspects are explored extensively elsewhere (Dumont et al., 2010; Stilwell et al., 2004; Taylor, Hwenda, Larsen, & Daulaire, 2011; WHO, 2006, 2010). Equally, this research does not focus on the managerial or financial aspect of international students since this has also been well researched and commented on (Altbach & Knight, 2007; Brown, Lauder & Ashton, 2008; Clark, Stewart & Clark, 2006; Dumont and Zurn, 2007). It does, however, use the detail of this particular context of a cross-nationally situated course of study to consider the complex and overlapping social, cultural, organisational and personal issues in relation to professionalism and education that are generated through the movement of peoples around the world.

1.6 Thesis Outlined

In Chapter Two, I explore previous research and theory relevant to my research project in the form of a social science literature review. Firstly I outline my approach to the key research concepts of identities and culture. Giddens (2013) suggests that the purpose of studying physiotherapy is to learn how to *be* a physiotherapist and so constructions of identifications create a view of professional learning. The activities that people undertake relating to their job roles (Taylor, 2004) can be seen as their professional identifications and so they form a particularly useful construction with which to explore physiotherapy, a profession defined by its treatments (Gee, 2000). These identifications, whilst expressed individually, are formed from the structural contexts that shape our shared cultural worlds of practice and education. In this way identifications indicate a view of culture as forged from structure (Bourdieu, 1977).

The discussion in Chapter Two centres on the two cultural worlds that contextualise the project, that of practice and of education. So, after I define key

concepts of identity and culture in relation to structure, I consider the structural influences on professional practice, and a discussion of issues of power, autonomy, influence and forms of capital become inevitable (Bourdieu, 1986a). I focus consideration of professional status on cultural capital since it offers a useful construct to explore both patient and therapist interactions as well as forming a tool to explore the different national forms of physiotherapy. Social capital is a useful way to understand the relationships between people (De Silva, McKenzie, Harpham, & Huttly, 2005), and different levels of cultural capital have a role in the reproduction and adoption of professional identifications (Holland et al., 2001) as well as forming a way of viewing the symbolic meaning(s) of practice (De Silva et al., 2005).

After considering physiotherapy practices, I undertake a review of literature associated with the physiotherapy profession - its history, development and current influencing structural issues - to provide a broader context to the analysis of my interviews. Finally I review literature relating to the second cultural world of the project, pedagogy in the context of international students. There is a strong element in this area where international students are viewed very much through a normative lens, much as I did myself in my early working practice, where students are seen as the exception to the host country's behavioural and social rules. I use an awareness of critical race theory (Delgado & Stefancic, 2012) to explore the meaning and consequences of this, an important starting point in how to avoid racism in both my research and my teaching practice.

I then separate out the 'underpinning thinking' and the 'undertaking' of the project, presenting these as two separate, but linked, chapters in Chapters Three and Four. This is mainly for clarity, since my reasoning around theory developed as the project progressed. In Chapter Three I offer an outline of my research journey to include reflexive considerations such as my initial hesitations around phenomenology methodology and the reasons why I finally describe my approach as "constructionist and interpretive". Because I use understandings from Holland et al. (2001) to gain perspectives relating to identity, identification and culture, ultimately the analysis is rooted in these

ethnographic perspectives. The methodology fuses an approach founded on participant experience, my self-awareness and appropriate theoretical support to construct both the methods through which I collected the data and the perspectives and ways through which I have arrived at my analysis. I expose the influences that have been brought to bear and show how they have shaped my work. I am aware of the personal as well as professional resonances for me in the work I have done and this chapter offers a consideration of the literal, as well as conceptual, journey on which this project has taken me.

In Chapter Four I use the ideas from the literature review and the approach outlined in Chapter Three to explain the research methods. Having already recognised the importance of issues of race and inequality in the research arena, ethical issues arise for all aspects of the research and I discuss how I engage with them during the research project. Also in this chapter I detail how I recruited and involved participants and explain how I have collected and transcribed the data. Finally, I offer an example of the multiple ways that I break the text down to find its many relevant meanings. I also discuss the other forms of data engaged in, such as researcher notes and diary and I demonstrate, as a way of exposing my analysis, how I undertake interpretive processes using NVivo software.

Chapters Five and Six contain my analyses of the participant's narratives. Inevitably, given the direction of my questions, my interest and aims, the cultural worlds foregrounded in my research are the arenas of practice meeting practice, and of national identifications within a pedagogic environment (Ruiz, 2005; Salzberger-Wittenberg & Henry, 1983). Chapter Five deals mainly with practice and Chapter Six mainly with education although they do overlap in places. The participant narratives are based in their understandings of how the profession functions in England, as much as how they used to work in India, and I focus on key areas of collective understanding of difference in practice between the two countries.

In Chapter 5 I present the outcomes of analysis in relation to the first set of research aims: i.e. the deductively recognised descriptions of professional identifications expressed by Indian physiotherapists towards the end of their English programme of study. The participants offered me views, albeit fragile and transitory ones, of their learning and meaning making and I explore them to develop ideas around structural and power discourses that shape the complex interrelationships in the therapeutic arena with both patients and other medical staff. I relate the aims of treatment to structural issues and determine the role of others (government or medical staff) in defining the treatments we offer. As I explore participants' understandings of what they are permitted and what they are not permitted to do in terms of their self-objectifications in treatment decision making, I outline the structural issues that underpin participants' working practices. Through self-objectification comes self-determination and the limits of their agency in different environments is also explored. Holland et al. (2001) expounded peoples' inventiveness when faced with the integration of very different practices and, whilst these for the participants were focussed around subversive stances to avoid control, rather than integration, some limited ideas regarding how their treatments might change emerged from their narratives.

The terms 'active' and 'passive' are present in teaching and are adopted by participants. They function as a 'common sense' means by which the teaching team understand and explain physiotherapy practice, but they do not bear close scrutiny. I deconstruct these expressions in the light of treatment approaches used in the two countries: manual therapy and electrotherapy techniques, the latter being a traditional mainstay of Indian physiotherapy practices. I discuss how changed approaches appear to relate to changed purpose of treatment - to address function rather than pain. Managing tensions between patients' expectations (demands) and therapist constructs of practice highlighted the importance of self-presentation and self-expression and the emergence of confidence as an important professional feature. This change in focus from pain to movement generates an awareness of the significance of effective communication and interaction with patients within a treatment session.

As I explore the meaning given to patient relationships expressed implicitly by the participant narratives, I draw on the concept of professional power as a form of 'cultural capital' (Bourdieu, 1986b, p. 241) to further my own conceptualisations of participants' descriptions of working. These notions of cultural capital and personal involvement in practice, are coalesced to arrive at a new model of practice, a model I have described as an 'engagement' theory of practice. It can be seen that as Chapter Five progresses my analytical stance moves from a deductive position to a more inductive stance as I theory build around physiotherapy practices.

Greater awareness of UK systems of structure, as well as the role of patients in practice, results in geographically situated perspectives of practice fading in relevance, as the similarities of practice, even those in different locations (particularly seen through the expression of cultural capital through professional skills) are highlighted. Viewing physiotherapy in this way exposes greater differences between public and private practice *within* nations, rather than that seen *between* national, cultured worlds of practice. The engagement model of practice can be seen to unify rather than divide the cultural world of physiotherapy. This theoretical model better explains physiotherapy practice than the expressions of activity or passivity currently utilised and it is applicable to any practice environment.

Chapter Six theorises around the meanings of pedagogy from the identifications expressed. Here I take the emergent theories outlined during earlier discussions and consider the meanings of these constructions to physiotherapy teaching in an inductive and interpretive way. In doing this I address the second research aim relating to what can be said with regard to the meaning of the cultural world of teaching.

In this chapter I consider the impact of what we, as tutors, tell the participants about themselves and their work in the light of hegemonic discourses. In reality, the worlds of education and practice cannot be said to be separate and they necessarily influence each other (vis-à-vis the participants' professional

identifications being generated from within the social world of the interview, which itself exists within a HE context). However the impact and meaning of the discussions in these contexts are different and so, on these grounds, I have separated them to focus on identifications as they relate to working in different environments.

The project exposes the hegemony of English practices within the curriculum as all participants demonstrated a strong uptake of these practice ideas, also indicating UK identifications beyond the classroom or physiotherapy practice. The labelling of Indian practices as 'passive' during teaching carries the implication that Indian therapy practices are inferior to English 'active' approaches. In failing to recognise Indian practices, English professional dominance is exerted and exposes a national power dynamic that acts to oppress Indian practices and their practitioners. A reductionist perspective of physiotherapy practice is revealed, where people and practices are viewed as essentially different (Holliday, 2005). The course is seen to exercise a subtle form of control, delivering messages of inadequacy which can have longstanding, detrimental impacts on people and their sense of self-worth and which may act to limit their achievement (Sennett & Cobb, 1973).

Micro power dynamics are features in all locations (Foucault, 1988) and the UK, with its history of colonialist outreach, could be said to have continued to largely ignore and marginalise those who are different, even with respect to health care practices. While the repression suggested is unintentional, the course presents a context where a lack of deeper engagement with students' understandings of their, and our, meanings of practice leads to an insistence upon UK practices, implying their supremacy. A constructivist perspective could be realised by exploring pre-existing Indian customs and building understanding, rather than projecting UK approaches. It can be seen that a curriculum more open to different practices and more alert to structural issues, could provide an opportunity for students to reflect on and develop their practice in a meaningful way within the context of their practice. And this would not even necessitate a massive curriculum change, but would require a conceptual shift towards the embracing of diversity within the course.

Internationalisation of the curriculum has been variously described, but essentially relates to teaching that is sensitive to diverse perspectives and transcends cultural relativism (Carroll & Ryan, 2007). An internationalised curriculum accepts that everybody in the teaching environment has identification perspectives and engages constructively and respectfully with these perspectives, to generate learning that is individually aware and it is to this, regardless of nationalities, that HE should strive (Haigh, 2002). I conclude Chapter Six with a discussion of the implications for practice and HEIs of the issues exposed.

The project has been a means of deepening my understanding of 'culture'. I began the research project with a concept of culture that was based around ideas of shared national identities and stereotypical notions of behaviour and attitude. I expected a homogenous response from a homogenous group of people who came from the same, homogenous, 'culture'. I expected that those from that same culture would experience the course similarly. However as the research progressed any fixed ideas of identity I had were challenged as its dynamic nature was exposed and consequently culture became a construct so seemingly undefinable as to be unsupportable. Finally though, notions of culture have re-emerged as having merit for consideration. They are not located within the individual – instead exist as an enactment between people, as a framework for a state of being. How enactment progresses at an individual level is influenced by many intrinsic and extrinsic factors and so it does not predict behaviour, but instead shapes interactions acting as a frame of normative reference for participants. It seems to me now that culture permits people to organise themselves (or be organised) in relation to the structures that contain them. Cultural ideas can be applied to physiotherapy practice where shared understandings of therapist actions and patient responses are fundamental to professional performances. It also applies to physiotherapy teaching, and here the subtle lines of power, existent in cultural exchanges become particularly visible. This issue is returned to and explored in more detail in section 7.6.

Looking back on my own cultural constructs, I can see that it can be hard to change these perspectives. Indeed, it took living and working on another

continent for 4 years to really challenge the euro-centrism and attendant sense of 'cultural supremacy' that I held. These experiences have made me appreciate how easy it is to perceive, and yet how hard it is to understand, the differences other people present with and through this failure to understand and unthinkingly undermine those we see as different to ourselves and those that think like us. I close the thesis (Chapter Seven) with a summary of the analysis and my conclusions. It considers the impact of the research, highlights limitations of the study and suggests potential future research as well as how it has affected me and my work.

1.7 Chapter Conclusion

I conclude this first chapter by outlining the contributions to knowledge the thesis makes in a context where there is little research about physiotherapy education or professional identity development. I have presented the research as both deductive and inductive. Deductive where I use a framework of established understanding to help describe my findings, and inductive where I continue to think creatively about my descriptions, using other theoretical guides to generate theory relating to physiotherapy as well as a critique of context. I realise that whilst I have presented these processes as clear cut, within the research they are intimately linked and where one process ends and another begins not always easy to see. My aim is to offer transparency of thinking, so that the origins of discussions can be seen.

Whilst I began by thinking about culture as a homogeneous construct, as my ideas about identity developed so did my understandings of culture and my perspectives of the research arena enlarged. Initially I considered that the research would relate just to physiotherapy practice understandings. However, I progressed to understand that the project takes place at a time and location where cultural worlds of practice and of teaching overlap, and so this research also offers considerations of the manner in which these students were taught.

This work offers a framework for viewing professional identifications, structural issues relating to physiotherapy practices and the development of migratory

professional identities. Participant narratives reveal the social construct of physiotherapy as a mutually engaged performance between therapist and patient. Confidence is seen as important in this engagement. Exactly what treatments are offered are set by structural and social confines that broadly determine what is undertaken and when. Physiotherapy is a combination of what physiotherapists do for the patient and what patients do for themselves. Treatment activities represent the professional domain of practice and they act to retain cultural capital with the therapist and these treatments are also symbolic of treatment meaning. In viewing these across national contexts, the similarities of cross national practice can be seen, rather than the differences, and a more nationally uniting view of physiotherapy is proposed, based on the engagement of both therapists and patients.

Secondly, in viewing a course where the differences in practices are highlighted and criticised, then the hegemonies of English pedagogic practice have been exposed. The propensity for oppression in education (no matter how subtly delivered) can be seen in the project. This aligns strongly with the work of others (Ladson-Billings & Tate IV, 2007) and contributes to the growing call for diversity in education to be embraced more strongly. The hidden traumas and potential for a loss of confidence is not known at present, but critical race theory suggests that, crucially, (and paradoxically in relation to what is also felt to be gained) self-worth may be negatively affected. It is pertinent to consider why Indian students submit to this situation, and this potentially relates to the transfer of cultural capital (in the form of credibility) that they can gain from the dominant cultural perspective.

During the project I had to acknowledge a sense of my own position as someone both contained and liberated, where issues of position are relative. I was constrained by my early education and working class roots, but also I have been able to travel and work in a very under resourced part of the world where all my life's restrictions were as nothing compared to the lives of people in the Amazon. In this way students too are constrained and freed: on the one hand oppressed by racism, but on the other academically free to explore themselves in the context of living in England. Possibly for reasons of my own background

and cultural positioning I have a tendency to consider students as disadvantaged, when they may not be. Many are wealthy, academic achievers from a growing economy, but that is not to say that they do not face pressure and prejudice. However sympathetic, a perspective that assumes it knows what students face and feel, is prejudiced.

In this chapter I have considered the research arena, physiotherapy as a profession and the motivating factors that supports the travel of Indian physiotherapists to the UK to study. I have discussed the impact of migration on them, and my experiences of international working that prompt my interest and my empathy with them. I have outlined my intentions for the research and the format the thesis will take as well as the contributions to knowledge it makes.

2 Chapter 2. The Cultural Worlds of Physiotherapy Education and Practice

This chapter forms a literature review of the project background context. I discuss definitions of the key research terms 'identifications' and 'cultural worlds' which I utilise to explore the meaning of Indian physiotherapists' study. In order to better understand the underpinning causes for the apparent disparities in professional working in India and England I review the different structural influences on physiotherapy practice to explore the power and autonomy of therapists in the two countries. Then I consider issues relating to education in this cross national context, particularly since the research area is one imbued with a colonial history.

2.1 Introduction

Professional practice and cross-national education present huge areas of study and it is beyond the scope of this chapter to offer an exhaustive summary of all available literature. I address them both, but in a focussed way, with the intention of imparting an overall understanding of the context of the research by justifying the overall shape and form that it has taken, using the pertinent aspects of the literature to substantiate my methodological approach.

In terms of practice, to understand the meanings participants have made from their study I have used constructs of culture and of identity. Here, I rationalise my use of these key concepts in the research and then explore physiotherapy as a profession so that the underpinning rationales for practices occurring in different countries can be better understood. I begin by defining identification and cultural worlds and apply these ideas to physiotherapy practice. In describing the way that physiotherapy functions in different locations I expose the structural issues that impinge and constrain practice. I also reveal the historical influences on practice that have shaped it into the form that it currently takes. Inevitably in doing this considerations of power and influence emerge as part of a deliberation with regard to professional status and function.

As I begin to describe cultures of practice, it should be noted that all participants were undertaking the musculoskeletal (MSK) route of the course. This relates to outpatient or orthopaedic working, which results in our discussions focussing exclusively on orthopaedic type practices. MSK physiotherapy is one prevalent specialism within physiotherapy - the other key areas being neurological, respiratory or paediatric practice (CSP, 2014). It, in effect, forms a cultural world of specialism within a wider cultural world of physiotherapy. Whilst creating a limitation with respect to the breadth of physiotherapy practice discussed within the research, concentration on just one field of practice allows for coherence between narratives to be more visible.

However it is not only the course content that influences students, but also other aspects of pedagogic practice and, in the final chapter section, I explore research relating to teaching and learning in a cross-national context. Here I take a particular and critical stance towards the research approaches previously used to view the learning of international students, in order to generate an appropriate methodology for the study. Together this information and these perspectives shaped the approach of the project that is outlined in Chapter Three.

2.2 Distinguishing between Identity and Identifications

Despite an often strongly felt sense of personal consistency, identity is not static; we constantly shape our self-presentation depending on whom we are with and where we are (Jenkins, 2014). This means that identity can only be understood as a process of 'being' or 'becoming'. It is work that is never finished or settled. Jenkins (2014) describes identity as a continual project, something that we create, maintain and revise to form a story of who we are, how we came to be and where we are now, as a reflexive understanding of our biography. Through this story diverse and contradictory biographical elements are integrated into a coherent narrative of our own. Given the difficulty then of discussing fixed 'identities', Holland et al. (2001, p. 7 & 8) refer rather to 'identifications'. Identifications are enacted, dynamic and changing, rather than

the static and singular condition implied by the term 'identity'. This position offers a more flexible and fluid construct with which to frame the vast number of potential and temporal identifications a person can make (*ibid*). Identifications present opportunities for belongings and rejections (all of which are potentially contradictory), through which people individually and collectively understand their locatedness and social relationships (Weeks, 1990). We all create, and continually rework, a sense of who we are and what we do. These identifications provide a means of making sense of lived experiences. Through the stories and descriptions of their work, as they envisage themselves undertaking treatments and describing their treatment preferences, the participants reveal the sense they make of their learning (Giddens, 2013) and the formation of professional identifications.

Giddens (2013) suggests that when tradition dominates, we do not have to think much about our actions but, in a situation of change, the self is challenged to a greater extent. The globalisation processes of easier travel and communications, as well as global economics have facilitated health worker migration from one culture to another and, hence, have stimulated huge challenges to 'self' as these workers start a new life in a different environment. Students moving from one geography and culture to another physically embody the life trajectories or journeys suggested by Giddens (*ibid*) and Bauman (1996) to describe postmodern life experiences. When faced with the tension and confusion that altered identifications create, the response of the self is to generate new selves (Humphreys & Brown, 2002b) and new ways of being become apparent (Holland et al., 2001).

Exposure to English assumptions about physiotherapy practice generates new understandings for the research participants that go beyond their acquisition of knowledge and skills, to include identification effects. These are the transformations they express as they negotiate the tensions and ambiguity between what they were and what they could be in the new situation in which they find themselves (Lincoln, 1997). Howells (2002) suggests that these changes arise through social interaction and through collaboration with other learners in a shared social, organisational and cultural situation. It is these

located practices of the classroom, as well as the professional content of the course, that come to the fore in this research. The classroom becomes a place of interaction and communication between cultures and, according to social learning theories, also a place where practice knowledge can be shared about the complex behaviours, skills and attitudes involved in working as a physiotherapist (Sarpong, 2008). So the remembered world of practice in India, the perceived world of practice in England and also the contemporary setting of the interviews (the world of UK Higher Education) are the social and creatively imagined worlds through and within which our discussions flowed.

There are different views of identifications, and these form a spectrum ranging from entirely individual to completely social constructions and these form different areas of study. For example, psychological perspectives focus on identification as a mechanism through which the issues relating to personhood and psychotherapy can be explored (Craib, 1998). At the other end of the spectrum, Foucault (1988), early on in his career, argued that, despite appearing to come from within, identifications were in no way individual or internal. He suggested that society - with its power constraints, rules and regulations - forms restraints, and what is internally felt are actually projections onto individuals from the outside. However a compromise view suggests that identifications can be used to explore the understanding of both individual and collective ways of being (Humphreys & Brown, 2002b) and reveal both the psychological and social environments in which narratives are located (Holland et al., 2001; Merriam & Heuer, 1996). It is this understanding that I use in my research, one that recognises the structural forces that contain and shape our practices, but also embraces individual agency.

The construct of agency is inextricably linked to identification. Defined as the self-determination capacity individual actors have, agency relates to the individual's efficacy in expressing or practice their identifications (Holland et al., 2001). It defines their freedom(s) to choose what to be and what to do in any context. Naturally the different views of identity generate different levels of presumed agency, with psychological and individual focussed research frequently perceiving high levels of self-determination while perspectives that

include an awareness of structural issues observe the restrictions these exert. Structural aspects that define practice and restrict agency in physiotherapy can be seen to be exerted through the traditions and institutions that regulate practice. There are shared expectations of practice in England and India, as seen from a cursory look at the professional body websites for the Chartered Society of Physiotherapy (CSP) and the Indian Association of Physiotherapy (IAP). Indian physiotherapists entering into a new structural context through their relocation to England, find their identifications challenged, through the different working culture they encounter.

2.3 Defining Cultural Worlds

But the social nature of an environment is a difficult concept to capture. As early as 1952, 164 different definitions had been suggested for culture (Kroeber, Kluckhohn, Untereiner, & Meyer, 1963). 'Culture' has been defined as shared identities (Baumann, 1996) rendering it equally contextually bound as identities. Interestingly Holland et al. (2001) discuss identification exhaustively, but explore the meaning of culture relatively little, because the terms become almost interchangeable given the socially and contextually derived nature of even individually expressed identifications. However, if cultures are shared 'identities' and we recognise that identities fail to conceptualise the fluidity of our self-constructions, then culture is also insufficiently flexible as a construct.

Professional identifications - the beliefs, values, behaviours and activities of a professional group - just like individual ones, are constantly revised (Williams, Brown, & Onsman, 2012). They are shaped by a profession's history, the economic and political relations of subordination and power that exist in the containing environment (for example, through government health care policy) by the society it functions within, as well as through individual responses to these external factors. As physiotherapists we continually integrate external events into our ongoing story of our professional selves (our professional constructs), and changes in practice occur over time as a result.

The limits of this terminology can also be seen when one considers the multiple and overlapping contexts contained within the research arena. The socially agreed aspects of physiotherapy do not form a single construct: there are regional differences in both countries around how physiotherapy is practiced, particularly true for a country the size of India, but is also true in my experience of working in England. And in terms of representing academic culture there are different expectations within the institution in which the programme is taught and the institutions from which students come, in addition to the individually held ideas of those that teach and learn on the programme (Laitinen-Väänänen, Talvitie, & Luukka, 2007; Parry, 2004). It can therefore be said that there are multiple cultures at play in the classroom, which go beyond the initially perceived differences between English and Indian national cultures, and include professional and teaching cultures as well as the individual expression of customs. Reference to a single 'culture' is clearly an over simplification in the light of the diversity of the cultural environment in the classroom.

A perspective that acknowledges shared behaviour and attitudes in relation to structural influences comes from Bourdieu (1977). He proposed a concept of 'habitus' rather than culture; the outlook which standardises the range and types of action possible as a consequence of the specific features of a social arena. Habitus differs from the notion of 'culture' as shared identities, because it represents a more complete view of the structural and environmental in addition to the social. Habitus maps and explains the impacts on a field of 'power' influences in any context. Some of these are social, some political, symbolic or financial, but through the different forms of capital he saw at play, the decisions and preferences of individuals appeared standardised and regulated. Improvisations are the sort of spontaneous acts that occur when our past, brought to the present, meets with a unique blend of circumstances for which we do not have an established response. This improvisation, according to Bourdieu, is the 'art of living' (Bourdieu, 1990, p. 74) and represents independence (Qasim & Williams, 2012). So, when faced with the new 'habitus' of practice, Indian physiotherapists frame their learning experiences by what they already understand, and improvise new ways of being, contextualising phenomena in both social and practical ways (Welikala & Watkins, 2008). From

this perspective, both structural elements as well as individual actions are seen as exerting an influence (Wight, 1999). In other words the participants' understandings are unique, but shaped by their individual experiences, history and context (Guba & Lincoln, 1994).

Holland et al. (2001, p. title) developed this construct, expanding a theoretical underpinning for habitus which they term 'cultural worlds'. Despite the expansion in its theoretical base, Holland et al.'s (2001) definition of cultural worlds appears to have a very similar meaning to Bourdieu's concept of habitus (1977). They both use their constructs to explore the structural frameworks that impinge on groups of people but Holland and her colleagues placed the considerations of identifications within a context of cultural psychology and sociology, to give greater recognition to individual freedom or agency than Bourdieu (*ibid*). Bourdieu considered the development of identifications mainly as an intergenerational issue of tradition, perhaps as a consequence of the context in which these ideas were conceived. The immediacy of impact on individuals gives Holland and her co-researchers' perspectives (Holland et al., 2001) an explanatory advantage through the agency they recognise. I adopted their perspectives on cultural worlds for my research and this perspective forms a lens through which I analyse my findings.

Before I engage in an exploration of the cultural worlds within the course, having identified the importance of structural issues when referring to identifications and cultured worlds, it becomes essential to expose the various structural constraints existent in each location. Structural issues in professional practice are generated though history, professional regulation, society and expectations regarding practice, so it now becomes pertinent to outline the various national histories and constructions of contemporary practices to envisage the structural aspects of different locations.

2.4 Physiotherapy as a Profession

Professions develop from a variety of contextual forces (Morrison, 2006) and physiotherapy in the UK materialised from a series of key historical and social

events, rooted in considerations of teleological effectiveness in health care. The professionalisation of physiotherapy in India has taken a very different route, the driving forces for professional development being based in different geographical, historical, social and financial contexts. Change pressures on professions emanate not solely from the state or other professions, but also through environmental conditions and social expectations (Ritzer & Walczak, 1988), although these issues are strongly linked.

2.4.1 A Short History of Physiotherapy in the UK

Physiotherapy was initiated in the UK in 1895 when the Society of Physiotherapy was established by nurses and midwives, and it expanded rapidly after the First and Second World Wars in response to the inability of traditional medical services to cope with the large numbers of war casualties (Blackledge, 2006). Despite it being a time of considerable economic constraint physiotherapy was enabled to advance its professional position through the intense need for rehabilitative specialist services. The pressure on medical staff to concede their activities to other health workers has continued to enhance the role of physiotherapy in the latter half of the 20th century (Daker-White et al., 1999; Nancarrow & Borthwick, 2005). The capacity to offer 'first contact'[9] health care was established in 1977 (Øvretveit, 1985). The increasing level of professional responsibility has resulted in increased academic demands and, in 1994, physiotherapy along with other allied health professions became a degree entry profession (Trueland, 2008). The link between education and professional development can be seen as greater academic achievement has further stimulated professional development. Since 1996, for example, limited prescribing and injecting authority rights were delegated from medicine to specifically trained physiotherapists (Morris & Grimmer, 2014). Despite its growing influence the profession retains a member profile that is consistent with its origins and in the UK is predominantly white, middleclass and female (Harvey & Newman, 1993; Mason & Sparkes, 2002).

[9] First contact status permits physiotherapists to diagnose and treat patients independently without an initial referral from a medical practitioner.

These professionalising pressures are consequent to a bureaucratic need for efficiency within health services arising from a shortage of health care workforce in a country where the population is aging. The dominance of degenerative conditions, such as osteoarthritis and coronary artery disease, has resulted in a departure from curative treatment approaches towards a greater emphasis on condition management (Lorig & Holman, 2003), particularly when the majority of the empirical evidence relating to practice suggests that much of the therapeutic benefit to physiotherapy treatment lies in client participation in exercises (Jones, 2010; Peat, 1981). Additionally, rapidly changing technology, increasing community expectations (WHO, 2006) and the high costs of national funding for the NHS, means that rehabilitative services now seek to restore to clients their independence and therefore also their economic function.

As a consequence of greater focus on management of chronic conditions, therapy practice has changed, moving away from the techniques of early physiotherapy practice of massage and electrotherapy. UK physiotherapy has been compelled towards self-help measures, adopting advice-giving and exercise prescription as key forms of treatment (Higgs, Hunt, Higgs, & Neubauer, 1999). The increasing focus on science and evidence based practice at the heart of the profession has created tension within physiotherapy around the de-professionalising influence of exercise prescription, (which are techniques that can be delivered by others as well as controlled by the patient), and the professionalising specialist skills (Higgs et al., 2001) that a physiotherapist can perform, such as electrotherapy and manual therapy.

At the inception of the NHS in 1948 a largely similar health service emerged within the four countries that comprise the UK. However since 1999 health care has been partially devolved to local administration and as a consequence some distinct differences have emerged in health care service provision and governance (Bevan, 2014). Equally there are some clear measureable differences between the countries in terms of issues such as numbers of GPs per head of population, length of hospital stay and even life expectancy. It is unclear what this means for the physiotherapy practices commissioned (and continuing to evolve) for the populations of these countries, but it indicates that

there are likely to be differences between countries. Interestingly the students refer consistently to the UK rather than England in their narratives, but that might be due to as much to the terminology that I tend to use as well as that prevalent within the course and its failure to notice these emergent differences between the countries that form the UK.

After noting national differences, it is also true to say that there are regional variations in health care services within England, many of which are not fully understood (Appleby et al., 2011) and so the environmental conditions recognised by Ritzer & Walczak (1988) occur at many levels of geographical division. Given the difficulty of addressing these differences, I restrict my comments to country level (England) since discussion addresses the uniting strucutral features for practice, but appreciate that it could represent an over-generalisation when considering practice throughout the country. And this problematic issue of naming cultural arenas through a national identification is even more pronounced when considering India, an enormous land mass with hugely diverse communities. Given the overalapping and contradictory nature of identifications, there are very great constraints on the capacity to generalise professional constructs when taking the narratives of so few individuals from diverse locations in India. However despite this, professional legislation applies to physiotherapists across the whole of India and it is then possible to discuss aspects of Indian professional culture at a country level through this framework of governmental control.

2.4.2 A Short History of Physiotherapy in India

Physiotherapy reached India just after the Second World War and it was most likely imported through colonial and charitable routes (Kale, 2003; Premkumar, 2010). The number of physiotherapists qualifying in India has risen significantly recently, demonstrated by the rapid expansion in the number of colleges providing physiotherapy education - from 52 in 1999 to 205 in 2004, an increase of nearly 300% in five years (Daker-White et al., 1999). The drive for this increase is likely consequent to economic advancement from recent

industrialisation (Reddy et al., 2011) enabling more technologically advanced and specialised health care for at least a proportion of the population.

The new affordability of health care for the burgeoning Indian middle class has resulted in the emulation of health care practices already established in better resourced areas of the world (Turner, 2007), thus further supporting the development of physiotherapy in India. Musculoskeletal rehabilitation, for example, is growing in tandem with the newly flourishing, skilled, but office bound, workforce and the longer life expectancies for some portions of the population (Saiyed & Tiwari, 2004). Greater opportunities to travel and work as a consequence of globalising processes allow for advancement of HE provision within India, even whilst its health care system continues to struggle to meet the need of its population (Peters, 2002). All medically related professions enjoy a relatively high status within India (Gokhale & Sasidharan, 2012) which make them an attractive career choice, but also social changes have brought some new freedoms for women (Gupta, 2006). These developments support the career aspirations of a newly emerging, majority female and middle class health professional (Van Eyck, 2004). This can be seen reflected in the health worker diaspora and the feminisation of global migration has been recognised in relation to professional practices (Sassen, 2003). Some of the very rapid expansion in the number of graduate physiotherapists in India could be as a consequence of Indian HE response to migration opportunities for its health care graduates, producing 'exportable' practitioners, noting that India is frequently challenged to find employment for its newly qualified physiotherapists (Sahni, no date).

Once exposed to the different structural arenas in each country, the profession has developed differently. Now, in the context of the MSc, the diverging forms of the profession have met. In order to explore these differences an analysis of the structural influences on the profession is required. Sandstrom (2006) describes these influences as a complex web, revealing their close, interlinking association. But these pressures on professions are not static. They form an ever changing backdrop, the framework for professional evolution (Giddens, 2013) which I now explore.

2.5 Professional Power, the State and Society

The concept of the professional has developed over considerable time, from the Middle Ages, when professions such as law, ministry and medicine shaped our definition of 'profession', to the last century when these criteria were attributed to virtually anyone receiving payment for activity e.g. entertainers and sports people (Williams et al., 2012). This change and the many expressions of professionalism have resulted in a number of sociological theories being developed to explain or understand a profession as a social construct but it remains a contested term (Ritzer & Walczak, 1988).

The limits to autonomy delineate the mechanisms of control for physiotherapy practice. The changing state of professional practice can be seen through its changing levels of autonomy and these can be seen through the acts that physiotherapists are permitted to do (Sandstrom, 2006). Analysing perceived autonomy can expose differences in professional working in different locations which also exposes identifications of practice (Holland et al., 2001). Regulatory control is an important manifestation of the power relations involved in practice and I discuss this before moving on to explore inter-related environmental and social issues in autonomy. Finally I outline current tensions in practice for the profession that these structural elements generate. It is these tensions that form the background context to the participants' narratives of their ways of being.

2.5.1 Physiotherapy Regulation

In the UK the Health and Care Professions Council (HCPC) is the state funded organisation that undertakes the registration of practitioners, regulation of practice and execution of disciplinary procedures for physiotherapy – not the professional body (the CSP). The bureaucratic function inherent within the government funded NHS is that its rehabilitative services are supplied in order to return people to productive and tax-paying work or to minimise the cost to the public purse through reducing the costs of social care. Government requirements for evidence based practice in clinical decision making can be seen reflected in the HCPC's Standards of Proficiency for Physiotherapists (HCPC, 2015). These standards also represent government control of the

profession. Indeed Foucault (1988) recognises state involvement and professional collusion in practice, extending his argument to suggest that some professions have taken on the role of control of the people on behalf of the government. Foucault's assertion that professions work with the state to construct normative behaviour and develop tools to subjugate the non-compliant seems farfetched until one examines the role of physiotherapy in activities including health promotion, such as smoking cessation and cardiac rehabilitation or 'return to work' projects for the long term unemployed and people with chronic pain conditions (DfH, 2008). Through the dominance of the 'return to work' ethos in physiotherapy practice the physiotherapy profession in England can be said to acquiesce to the state in the nature of its practice. The clinical decision making autonomy granted to physiotherapy in 1977 may have merely acted to remove the influence of the 'middle man' - the doctor - in the control of medical services, and placed physiotherapy directly responsible to the state, rather than offering complete autonomy. It can be seen how Illich (1978) came to propose that professional functioning is a means by which an occupational group is able to monopolise a domain of practice though its relationship with the state. However this argument focusses on a limited perspective, and fails to take account of society's views of this arena. The profession's claims for influence rest on its capacity for rationality and the justification of its decision making and through these claims it generates cultural capital (Bourdieu, 1986a).

A profession is not only defined by the state, but is positioned relative to others (Freidson, 2001). Medicine, as the profession from which it emerged, forms a key comparator for physiotherapy. Indeed in India, regulatory control is exerted, not by the government, but by the medical profession. This forms a critical divergence in the structural arena between India and England. In India a high proportion of medical staff work in the private sector where efficiency is not an imperative since there is a surfeit of medical staff for those that are able to pay (Bhat, 1999), community expectations are low (Brugha & Zwi, 1998) and the population youthful. The lower incidence of chronic conditions necessitates less health care provision (Dyson, Cassen, & Visaria, 2005). It is hardly surprising then that the Parliament of India has refused permission to the Indian

Association of Physiotherapy to remove the words 'under medical direction' from the definition of physiotherapy, or to establish its own Independent Physiotherapy Council despite lobbying from physiotherapists (Selvam Ramachandran, 2010). The Indian government justifies this decision by citing lack of supervision or control of the quality and standard of education in the many physiotherapy training institutions (*ibid*). This might be as much a comment on the capacity of The Medical Council of India (MCI) to set up and manage such a quality control system. The MCI, the statutory body for maintenance of uniform and high standards of medical education in India, was disbanded temporarily in April 2010 in the light of a corruption scandal involving its president (Sachan, 2013). This situation serves to demonstrate a lack of functioning professional governance in the highest echelons of professional practice in India and forms a chaotic backdrop for professional development.

The net result is that any extension of autonomy of practice for physiotherapists in India will continue to be blocked due to the profound lack of teleologic need for the government to instigate greater levels of professional independence for physiotherapists. No matter how vigorously physiotherapists lobby for 'first contact' status (see footnote 7), this is unlikely to be granted whilst the Indian government is not able to meet the health needs of its population through its public health care system (Balarajan, Selvaraj, & Subramanian, 2011).

A paradox becomes apparent here however, as treatments prescribed by the referring medical practitioner in India are frequently vague. This permits a wide degree of interpretation, so physiotherapists can be creative within treatment encounters. If they eventually work in England, graduates may be surprised to find that they have less day to day autonomy in work in a better resourced healthcare system than in their own, apparently prescriptive and controlled, but laxly regulated, environment in India. These influences of state control have implications for the application of learning at M level and become apparent in the analysis (see section 5.2).

2.5.2 Social Aspects of Structural Control and Cultural Capital

Freidson (2001) suggests that professional status is bestowed from the outside, not just claimed from inside a professional body. Although entry to the profession in both countries is through undergraduate degree qualification, most physiotherapists in India call themselves 'Doctor' (Kumar, 2010) in contrast to the UK where this title is prohibited. In India, where education is expensive and only a minority achieves tertiary education, greater levels of respect are shown to those with a university degree. In this way it could be argued that Indian therapists command a higher professional status than physiotherapists in the UK.

Evidence suggests physiotherapy intervention can occasionally have a negative impact on patients, some being frightened by the physiotherapist suggesting restrictions in activities, or pressurising them to undertake activities (notably exercise) they believe to be harmful to their health (Hay et al., 2005). This conflict between professional and public concepts is conceivably even more present in India, where a strong faith in Ayurvedic medicine prevails in the general public (Khare, 1996). This difference can also create disjunctures in the understanding of health between physiotherapists and their clients, whose understanding of ill health may be far from scientific. The UK government has, in recent years, written service user rights into legislation (Department of Health, 2003). Here it becomes difficult to disentangle patient (societal) and state control, since it is government legislation that challenges the physiotherapy profession to include a client perspective within practice. However, regardless of whether this is seen as client or as government power, compliance with this creates another paradox: patient wishes may conflict with the government's requirement for increased use of evidence based practice.

Internal claims of professional status are manifest in physiotherapy's focus on clinical reasoning and professional judgements, which tend to align authority and prowess with the physiotherapist. The adoption of a biomedical discourse enables physiotherapists to wield power in relationship to clients (Nicholls, 2008). Indeed, the definitions of physiotherapy in chapter one (see section 1.2)

form examples of the distance professionals can create between themselves and their clients through the framing of their work in technical and specialist language (McKnight, 1977). And the continued reference to 'patients' within physiotherapy discourses (demonstrated consistently by the participants) is significant in this respect too. Other professions, notably in mental health services, have tried to contain or reduce that distancing within the professional relationship by adopting terms such as 'client', or 'service user' (Simmons, Hawley, Gale, & Sivakumaran, 2010). These social aspects of professional authority have been described by Bourdieu (1986a), and it is to an exploration of his concepts that I now turn.

Physiotherapists have authority over patients in terms of their treatment decision making and through the health care community by the command of resources. They also influence society more widely, through the structure and delivery of services. Bourdieu (1986a) proposed that this professional control is based in its knowledge, technical skills and education and through this a profession rationalises its higher social status and consequent employment advantages. He also suggested that this prestige is represented by a form of social or cultural capital. This means of viewing physiotherapy explains the permissions generated by practice and the status it draws, but there are issues with this theoretical perspective which relate to the clarity of concept definitions. Bourdieu (1986a) suggested cultural capital was either embodied, objectified or institutionalized, but these seem of limited explanatory value to physiotherapy practice since it contains elements of all of these: it is objectified as a visible or performed manifestation of healing actions; it is institutionalised (in both India and England) through its work predominantly within a public health service and it is embodied through the performance of treatments. It is also difficult to clearly distinguish cultural capital from Bourdieu's (1986a) other theoretical constructs relating to further forms of capital. For example, it overlaps with economic capital, given the status and steady wage a job in the health profession brings. Recognising that these categories merge into one another and have little meaning in isolation, I did not seek to distinguish between different forms of 'cultural capital' in my research. Therefore, when I refer to cultural capital in my analysis, I include all the non-material capital that

participants referred to, using it as a more global concept than perhaps Bourdieu intended.

A more troubling theoretical misfit occurs when considering another form of capital, symbolic capital (*ibid*). Anything that stands for, signifies or expresses something else is a symbol (Abercrombie, Hill, & Turner, 2006) and the relevance of symbols in health care have long been recognised by medical anthropologists (Helman, 2014). Geertz (1980) suggested that ideas are not unobservable, existing solely in the mind. Instead they are present in symbolic form and can be interpreted from the 'rituals, technologies and social formations' (*ibid*, p. 135) of everyday life. Physiotherapy practice involves a transient social interaction between physiotherapist and client, where interactions form key aspects of the process (Thornquist, 2001). Symbolic representation is exemplified in physiotherapy, given that treatment effects are frequently not instantaneous or particularly observable but are instead felt and perceived. The techniques employed by physiotherapists can then form a symbolic representation of the invisible, 'healing work' that practice represents. The shared meanings invested in treatments are then a symbolic portrayal of the therapist and client collaboration. It is difficult to draw on examples of this view of practice because, whilst the symbolic nature of practice has been recognised by other forms of medicine (Kielhofner & Burke, 1980), this remains largely unconsidered within physiotherapy.

However, despite the blurred definitions of Bourdieu's (1986) theory, the concept of cultural capital is useful in explaining the status and influence of physiotherapy and this, in conjunction with an understanding of the symbolic meanings of physiotherapy treatments (Geertz, 1980), generate a theoretical framework through which to view both who physiotherapists are and what they do. It is ironic to note, after outlining the rationale for evidence based practice as a source of professional status, that the body of evidence for physiotherapy practice actually contains very little robust, specialised knowledge. Many of its treatment techniques have been recognised as having an insufficiently grounded theoretical basis (Higgs et al., 1999). Higgs et al. (2001) go so far as to suggest that physiotherapy is a semi-profession on these grounds.

Electrotherapy and manual therapy are two examples of skills unique to physiotherapy practice and both, despite their widespread usage, have little scientific evidence of effectiveness (Gross et al., 2004; Ho, Sole, & Munn, 2009). These techniques can therefore be seen as highly symbolic forms of cultural capital. They mean something to the people that use them and those that receive them; they hold a meaning beyond their effect. Since these treatment approaches dominate in participant discussions, I now consider them in the context of practice in the two countries as a background to later discussions.

2.5.3 Symbolism in Practice

Electrotherapy has formed a mainstay of physiotherapy practice since the profession's early development in the UK in the 1920s and remains one of the four pillars of the scope of professional practice (French & Dowds, 2008). Its use has waned in England over the last few decades (Shah, Farrow, & Esnouf, 2007) possibly due to evidence showing that some forms of electrotherapy can be detrimental (Johnson & Guy, 1972). These techniques apply electromagnetic wavelengths of various kinds (e.g. ultrasound, short wave, magnetic) and are generally thought to promote healing and reduce pain. The lack of structural drivers for development within India outlined previously have resulted in physiotherapy practices remaining relatively static, with treatments similar to those first transferred there in the 1950s, such as electrotherapy, remaining prevalent.

Conversely, social and political changes in England have influenced changes in practice. One such change has been in the development of manual therapy techniques (see glossary of terms) and the diminished use of electrotherapy over the last 30 years. Whilst manipulative therapies had existed previously, a new and greater uptake of these techniques was pioneered by Geoff Maitland[10] who founded the International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT) in the latter half of the 20th Century (Ottosson, 2011), and

[10] Maitland was highly instrumental in developing the techniques of mobilisation and manipulation.

the emergence of these practices also coincided with the decline of electrotherapy (Shah et al., 2007). A reason for this change in physiotherapy practice might be found in the government's changing requirements from health services at that time, but also related to the inherent characteristic of symbolic meanings contained within acts of treatments (Bourdieu, 1886a). As demographics have altered in England towards a more aged population a greater prevalence of chronic conditions has emerged and funding pressures within the NHS have directed treatment foci towards a more functional approach. When viewing this from a symbolic and ethnographic perspective (Geertz, 1980) Maitland's approach can be seen to have become popular because of the little nudging movements of which it consists. They figuratively represent the aim of treatment, which is for greater joint movement and mobility. In such a way the symbolism of manual therapy completely integrates and aligns to an exercise approach towards treatments.

Like electrotherapy, the utilisation of manual therapy runs somewhat contrary to government requirements of practice based in scientific evidence and patient involvement in health care (HCPC, 2015) and so it appears that one form of scientifically weakly justified form of physiotherapist applied technique, electrotherapy, was usurped, by another, manual therapy. Freidson (2001, p. 131; referring to Jarausch, 1985), points out that some professional ideologies can resist the external control exerted by government policy and the inherent pressures on autonomy. In this development physiotherapy can be said to have subverted, rather than challenged, the political message of evidence based practice by adherence to these techniques. Whether physiotherapy uses manual therapy or electrotherapy it could be said to approach the therapeutic interactions in a similar way, with physiotherapists holding cultural capital through the delivery of symbolic treatments. Which approach is utilised depends on the context, as it is this that establishes the expected and shared meaning of treatments for the recipients of them.

2.5.4 Summary of Structural Influences

Physiotherapy in India was imported from the UK in the middle of the last century, but different structural issues influenced practice in England and India. Superficially it might be said that UK practice has complete technical autonomy with its capacity to undertake first contact care but it is impossible to avoid controlling mechanisms apparent in the socioeconomic sphere within a teleologically influenced environment. In India, structural issues appear more obvious, through the direct control of physiotherapists by medical practitioners, but the impacts of these are less clear given that the Indian professional environment is less bureaucratically certain and therefore more open to social variability. Techniques of practice relate to the location of cultural capital with the physiotherapist. Physiotherapy consists of symbolic practices, the meanings of which are shared with the patients and which align to the underlying purpose of treatment.

There is little (if any) conscious awareness within the profession of these issues of symbolism or structural control in practice. Instead they manifest themselves as identifications within locations and it is these identifications that are shared during cross national education.

2.6 Research Approaches in Cross National Education

Unlike many post graduate taught programmes with predominantly international student cohorts, worldwide perspectives formed an insignificant part of the MSc curriculum studied by the participants and course tutors had little teaching experience beyond Europe. I led a module which explored issues of professionalism, but it was low in credit value compared to clinical modules. Arguably the programme did not need to be globally focussed, given that the students largely expected to work in England. However, as already explained, visa changes altered the context of the MSc students' learning, and we have very little idea about their emergent practice understandings or what happens to these understandings as the alumni return home (Brown, 2009a). Pedagogic theory and practice assumptions about how students incorporate (or otherwise)

the ideas encountered in learning (Fontana, 2002) have not been tested and this research provides an opportunity to do this.

Much of the previous literature on cross-national education within universities assesses managerialist issues (Altbach & Knight, 2007; Taylor, 1996). Reductionist approaches act to focus on and define student experiences and, in an arena where these experiences are not well understood, they are not appropriately exploratory or open. Disregarding literature about financial gain from international students, prevailing research in the arena of cross-national education is dominated by students of education, business or language. It is interesting to see how little relevance is given to health studies compared to business, notwithstanding the importance of health as a significant aspect of social being. Hird (1998) noted that individuals can struggle with the complexity of the postmodern condition and the limitless possibilities of what they could be, and identified the psychological stresses of such a disrupted sense of self. In the following pages I explore relevant research in order to justify my approach as well as contextualise the analysis. I consider both content and methodological issues.

2.6.1 Approaches to Studying Student Experiences

There are many ways to view the student experience: actor-network, enhancing agency, structured worlds, concept mapping, learning theories, cultural capital, liminality and various language approaches – some rooted more strongly than others in theoretical perspectives (Gertler, 2003; Goffman, 1959; Niezen, 2008; Turner, 1993; Worchel, Rothgerber, Day, Hart, & Butemeyer, 1998). It is beyond the scope of this chapter to address this complexity here but much of the early work with international students focusses on the negative experiences that incoming students have as well as their 'study characteristics'. It is typified by work that explores what the problems are and how to deal with them using a psychological and positivist framework of investigation covering language difficulties, academic challenges, social interaction, identity disruption and food habits (Barron & Arcodia, 2002; Kashima & Pillai, 2011; Kim & Aune, 1997;

Kosic, 2002; Ladd & Ruby Jr, 1999; Sheldon, 2011; Shen & Pedulla, 2000; Tatar, 2005; Ward & Kennedy, 1999; Westwood & Barker, 1990).

Psychological approaches consider many factors that may affect adjustment to foreign study: friendships with other international students of the same country and others and host residents; gender; country of origin and year in school; marriage status and learning styles. This type of work sometimes appears to produce rather self-evident results such as Al-Shariden and Goe (1998) suggesting that if an international student has a strong relationship tie (friendship) with a national, then adjustment is 'better', or that there are lower levels of academic achievement with lower levels of academic English proficiency (Kavanagh, 2008; Poyrazli & Kavanaugh, 2006). This work features the (di)stress of migrants to a great extent (Ahn, 2011; Brown, 2007, 2008, 2009b; Brown & Holloway, 2008; Brown, Lauder, & Ashton, 2008; Caluya, Probyn, & Vyas, 2011; Chun & Poole, 2009; Copland & Garton, 2011; Gu, Schweisfurth, & Day, 2010; Lee & Rice, 2007; Myles & Cheng, 2003; Neider, 2010) and perhaps as a result of this, psychological research in this area has also flourished.

Various constructed features of thinking and being have been explored and they appear to combine previously established identifications of individual psychological functioning into a single explanatory cognitive-emotional concept that can predict and explain the response of an individual to a cross-national experience. These constructs include 'locus of control' (Sheldon, 2011; Ward & Kennedy, 1992) and the 'need for cognitive closure' (Kashima & Pillai, 2011; Kosic, 2002) where this is a measure of the individual's tolerance of uncertainty. This research leads to confusing and inconsistent results as the constructs are measured differently between countries; different compositions of psychosocial measurement are used and there are varied means of generating psychological evaluation. Possibly as a corollary of the perceived lack of robustness of these results, or a lack of clarity around which issues are most pertinent, few papers tackle the 'next logical stage' in research where an interventionist approach would attempt to impact on the construct variable. Thus, few papers engage in experimental work to influence, measure or assess impact in the area of

international student transition, not even for the very commonly expressed issue of depression in international students.

2.6.2 Limitations to Positivist Research Approaches

It is overly simplistic to categorise all psychological studies as devoid of an appreciation of cultural complexity but, when comparing 'home' and 'international' student achievements, there is a frequent tendency to view the incoming culture in ways and through issues that pertain to the context and discourses of host nations (Giddens, 2013; Sheridan, 2011). Research into personal or group achievement is underpinned by an ontology of learning itself, which assumes that there is only one way to learn and that, generally, is host focussed. For example much work has been done about acceptance of and resistance to authority and learning styles without appreciating the complexity of these issues for both groups and individuals or the normative constructs employed to assess students. When viewed through the lens of the better resourced country, international students are frequently found wanting (Baskerville, 2003; Shen & Pedulla, 2000), which might explain why HE establishments often make wrong assumptions about their needs (Andrade, 2006).

One can question the epistemological validity of creating psychological constructs and the meanings that can be drawn from such techniques, but ontologically the danger is always that these generalisations become stereotypes, ways of seeing international students that group them to set national characteristics. This, because of the type of research it is based on, positions students as 'deficit' when viewed through our own cultural thinking and there have been consistent voices arguing against the dangers inherent in approaches of this kind (hooks, 2014)[11]. However, even using an empirical approach, differences are likely to be shown to be greater between co-nationals than between different nationalities (Apfelthaler et al., 2007).

[11] Note: hooks deliberately takes this form of name with a lower case h, rather than the more usual Hooks, in order to distinguish herself from her grandmother.

The kind of cultural projection that occurs during stereotyping is oppressive and objectively false. Even to refer to 'culture' might be seen as a static (and stereotype-laden) term. Despite its limitations, this approach is a dominant discourse in HEIs (Ryan & Viete, 2009; Watson & Wankel, 2000). As researchers in the field of learning and teaching have become engaged in these issues, there has been a progression from business concepts and other mono-cultural perspectives to post-modern thinking (Edwards & Usher, 2008; Lyotard, 1993) based on an understanding of the positionality of both cultures (Harré & Langenhove, 1991). Postmodern theory resonates particularly strongly with the practice of cross-national or multicultural pedagogy.

2.6.3 Focus on Agency in Educational Research

Through taking a positivist research focus, the power relationships inherent in the HEI setting are not recognised and, as a consequence, there is a concentration on personal agency. This can be seen for example in the literature on plagiarism (Le Ha, 2006) as there is an over representation of international students on academic conduct panels since they easily fall foul of the UK university rules (Carroll & Ryan, 2007). Viewing international students as freed from a past prescription of behaviour and attitudes and now liberated into 'choices' through their education is inherently problematic (Tran, 2011) in such a situation as the students are merely moving from one set of regulations to another.

HE staff frequently fail to recognise their impact on the difficulties students from other cultures experience. Bowl et al. (Bowl, Cooke, & Hockings, 2008) identified a dominant notion in HEIs of a difference between traditional and non-traditional students which forms a dichotomy of 'us' and 'them' for tutors. More contentiously Fine (1994) argues that social science research that centres on the 'sameness and difference' of host constructs has been used as a tool of domination. International students, when seen as 'other', become the oppressed in the hegemony of HE construction. Grimshaw and Sears (2008) describe literature that does not adequately address or acknowledge the power differential exerted by and through culture (Madge, Raghuram, & Noxolo, 2009;

McKenna, 2004; Rizvi, 2007) as a continuation of colonialism and this charge can also be extended to pedagogic practices.

2.6.4 Imperialism in Cross-National Education Research

Evidence of power discourses are present even in work undertaken by international researchers, as international students themselves begin to carry out Masters or Doctoral work in other countries (Chun & Poole, 2009; Gu et al., 2010; Lee & Rice, 2007). Whilst the sympathy of these papers is clearly with the international students, tensions emerge in all stages of the research process (Humphreys & Brown, 2002b). Tran (2011) for example, describes the meanings Chinese students make during their studies in Australia, through their resistance to or acquiescence of concepts presented. He neglects a critique of the relevance of their learning experience, but offers an outline of the economic benefit to Australia. In fronting Australia's economic needs over students' learning requirements, he exposes some of the power dynamic behind his PhD studies. The question 'who wins?' posed by Foucault (Saukko, 2005) is answerable in this example – and it is not the students.

The uneasy concept of 'espionage' emerges in some papers, where international students investigate the experiences of other international students in better resourced country contexts. For example, Myles and Cheng (2003) investigated the social and cultural lives of international students with a view to understanding their 'failure' to adjust to a Canadian academic system. Their direct and closed questioning methods about concerns appeared to produce contradictory findings as participants were deemed 'well adjusted', despite the quotes demonstrating their marginality within university life. It is possible that the intention was that co-nationals would help to explore sensitive issues but as Denzin and Lincoln (2011) have suggested, everyone who enters the research arena has their own unique perspective on the world and just because they shared a nationality it does not mean that they share any other identifications. Indeed there are many reasons why sharing feelings openly to someone reporting on them to the university might inhibit what is said. Nor does it guarantee interpretative imagination in the analysis.

Very little work is undertaken by academics from less well-resourced countries. One exception is Wang et al. (2011) where just the first author was based in a Chinese institution. This work is highly empirical, and asserts that it takes 3 weeks to get used to life in Australia and 4 weeks to adjust to new forms of study. This seems somewhat optimistic and definitive, and one has to question the rationale of this research and whether the author actually underwent a cultural exchange himself. Unfortunately the context of the research is not clear, but it appears that Wang may have been under some pressure from his co-authors (located in well-resourced country universities) to demonstrate minimal impact of travelling overseas to study. Power boundaries are no respecters of nations and the tentacles of academic practice in well-resourced countries spread a long way to exert their influence. Marketing ploys that co-opt (some might say manipulate) academics in less well-resourced countries to soothe the concerns of their home students and encourage them to travel overseas to study, seems a self-defeating strategy for less well-resourced country institutions. However it is easy to see how individual academics might be enticed by the prospect of international publication, enhancing their academic status or by the lure of international travel. These issues of national power dynamics and tensions between better and less well-resourced countries underlie the difficulties of really engaging with emancipatory and participatory research (Bartlett & Holland, 2002; Wood, 2005).

My research relates to the reproduction or adoption of different identifications to explain practice and this hinges on the power relations between the cultural worlds. Grimshaw and Sears (2008) suggest the potential for multiple identification formations or 'supra-national identification' where constructs from different locations merge. However Hancock (2008) suggests that learning does not result in an even merging of constructs. Learning spaces are not neutral environments and power sides with the better resourced host nations.

2.6.5 Project Implications Regarding Identifications

Previous research relating to international students has usually largely ignored the perspectives of the incoming student and this has generated a growing level

of criticism due to the innately ethnocentrically focused research that results (Ladson-Billings & Tate IV, 1995; Sheridan, 2011). The distorting impacts on human relations founded in racism are not only apparent in educational research. Critical race theory was generated in the 1970s as a consequence of the innate, structural inequalities seen as being perpetuated between different races across social science subjects (Delgado & Stefancic, 2012). The theory spawned a movement, a loose association between academics and activists with a commitment to transforming the relationships between peoples through the recognition of racial inequality (*ibid*). When viewing my research arena through this perspective, gaining a purchase on the relevance of race was important, particularly in order to address issues of domination in pedagogic practice. And the dangers of oppressive practices in education and research are numerous: Collins (1998) described the viewing of participants as merely sources of data as a 'smash and grab' approach to research. Clearly this would be ethically unsound, but it is easy to underestimate the difficulties of seeing experiences from and through the perspectives of others. I explain how I have tried to overcome these difficulties as I describe issues of methodology, my research journey and methods in Chapters Three and Four, but in reality I can do very little about issues of power and control. However I can recognise them and engage with them as they emerge within the research.

Development of one's practice, whilst the focus of my study, may not represent the entire perceived gain from study overseas. The actual act of travelling can generate a new awareness (Sinclair, 1997) and Schmitt et al. (2003) argue that the experience of being in the minority can cultivate a consciousness about the politics (context) of self. This perspective has links with psychotherapy, the undoing of identifications helping people navigate a plurality of contexts (Cutler, 2006), whereby a sojourn acts as a catalyst of self-expression (Brown, 2009b) and greater personal meaning. It is conceivable then that in looking at learning holistically, but foregrounding just professional aspects, important issues in personal development will be overlooked. Nonetheless, drawing boundaries with regard to the data gained was one way in which I was able to demonstrate respect for the personal lives of participants. As a consequence of the power relationship between us, they might feel obliged to disclose answers to any

question I asked them. But eliciting 'private' data creates a form of voyeurism, or fetishism, a pit-fall to which studies exploring the lives of 'exotic others' are prone (Kristeva, 1991). I sought to avoid the possibility of such criticism by maintaining the focus on professional issues and not straying into areas where I have no legitimate concern.

2.7 Chapter Conclusion

I have outlined and rationalised the theoretical perspectives that underpin the means of viewing the learning generated by Indian students in an English professional educational setting. I have defined physiotherapy identifications as the way in which we explain and understand our practices both to ourselves and to each other. They form the constructs through which I interpret participants' ideas and understandings (Marshall & Rossman, 2010). They offer insight into both the participants' structural context and individuality of response to their practice and education (Salzberger-Wittenberg & Henry, 1983). Social, environmental and political structures that impact on a field of practice can be thought of as encapsulating a 'cultured world' and the programme crucially creates an arena where the cultural worlds of English and Indian physiotherapy practice meet. I have already outlined the differences between English and Indian physiotherapy practices. Participants' identifications resulting from the course hold answers to their alignment to these practices, their identifications as a result of the course and these will inevitably be shaped by the relative cultural capital these practices hold. In turn, expression of cultural capital will depend on the power discourses between staff, the HEI and students.

I have explored the cultural worlds of Indian and English physiotherapy and literature relating to cross-national study as a means for understanding a professional learning environment. The chapter has also considered the cultural and hegemonic practices of education for international students, and the professional identity/identification basis of English physiotherapy. Having highlighted the different aspects of power relations between countries and the impact on educational research it is now pertinent to further consider how these impact on methodological issues in my research as a guide to my own ethical

considerations. The approach to the project was something that developed over time and I describe next my research journey: the story of how and why it became what it is.

3 Chapter 3. Methodology and the Research Journey

In this chapter I take the perspectives discussed in Chapter Two and incorporate these into an explanation for the developments that occurred during the research to justify my final ontological and epistemological approach to the research. This explanation takes the form of an outline of a personal journey charting methodological development. Inevitably my thinking has changed over the three years of undertaking the project and here I share my reflexivity to show how it shaped and defined its progress. I consider tensions and resolutions in data analysis, the description and conceptualisation of data and explain the nature of my recruitment to the project.

3.1 Introduction

A traditional approach would be to outline a definitive methodology. However, for me, the research process has been one of methodological development, gaining methodological certainty as the project has evolved. Qualitative research is formed from narratives and, in the spirit of this approach, in this chapter I offer my narrative of the research undertaken and in this way aim to contextualise and explain how I arrived at the final research stance. I consider the more specific impacts of the doctoral programme and the research itself as it progressed that were highly instrumental in the resultant form it has taken. Constructivist approaches are legion and I aim to navigate the blurred boundaries between research theories and methodologies in this research context, to provide an articulation of the principles I have adhered to and, in doing so, demonstrate the influencing approaches that have been brought to bear on the project. The approach I adopted draws together a number of these as a bricolage to explore practices (Schnelker, 2006). These practices are both physiotherapeutic and pedagogic, as by asking what Indian students 'gain' from the programme challenges both theory and practice assumptions contained within the course (Fontana, 2002) and these form the two areas of key analytical focus.

Research ideas began to form during the two years and the four taught modules of the Doctor of Education programme. Physiotherapy retains a largely positivist outlook, a feature of its history rooted in medicine (Boyce, 2006). Most of its professional literature is empirical in nature and, consequently, much of my development during the Doctorate in Education programme has been about expanding my understanding of the claims on truth that are made about physiotherapy, its practices and the limits to its body of knowledge.

It can be seen from Appendix 1 where I outline my approach to the literature review, how instrumental Module 1, 'Framing Your Research' was in seeing the context of the research arena particularly around professionalism and practice. In Module 2, 'Research Methodologies in Professional Education', I explored the concept of identities and at this point I understood that I would accept participants' presentations of their own, unique social realities (Mills, Bonner, & Francis, 2008) and engage in a constructivist qualitative study. This stance was not only an academic approach to professional identifications, but was also shaped by my life experiences (section 1.4) prior to the research. How Indian students made meaning around their professional practice brought about by their education in England was of interest to me and the multiple dimensions of the research reflect my own position as someone who identifies with being a struggling student, a tutor, and an educationalist as well as a physiotherapist. Module 3, 'Researching Pedagogical Practice' shaped the pilot study and generated much of the critical analysis of international student pedagogic research that forms the final aspect of Chapter Two. It was also here that I researched identity as a means of viewing learning and read the work of Holland et al. (2001). Whilst Module 4, 'Research Designs in the Educational Field' and the pilot study it comprised for the main research project was the point at which I was made uncomfortably aware of the racism graduates face in the world of work. As a consequence, I developed a heightened awareness around the ethics of my engagement with participants. I was aware of wanting to avoid cultural imperialism and any abuse of the power differences generated by me being a tutor and them being still students. This resulted in me being very keen to accept narratives from their perspectives.

Using constructivist approaches has allowed me to consider the impact of the participants' stories on my own development as my interest in studying people from another country can be seen as a means of deepening my understanding, not just of their identifications (Vidich & Lyman, 1994). And this stance allowed me to engage more fully with the concept of education, since Dewey suggests that learning aims to 'release the human potential for growth' (Garrison & Neiman, 2003, p. 28). This broad definition offered the scope of recognition for holistic, personal change for both the participants and me through learning of many kinds. I am not alone in realising this: Atkinson and Coffey (2003) have described research as simply labouring towards 'identity'. The Indian students' apparent labour with professional adjustment resonates strongly with me and I recognise that, lying behind the research project, are issues around my own search for meaning and what it means to be and become a physiotherapist, as well as the social aspects of practice of physiotherapy in different locations.

To avoid highly abstract ideas appearing unconnected to the narratives, grounded theory was the research approach used on which to base early data analysis (Glaser, Strauss, & Strutzel, 1968). The term 'grounded theory' has been suggested by Weed (2009) as being used indiscriminately to describe all inductive research and he implies this practice promotes a lack of methodological transparency in research. A critical issue for explanation in this research is around 'theoretical sensitivity' (*ibid*, p. 505) which relates to the extent to which existent theory impacts on data collection and analysis, given that they are so closely intertwined; with analysis guiding collection and collection influencing analysis. To continue the considerations of cultural aspects to this research, I use ethnographic theory based in the work of Holland et al. (2001) around identification and agency in the cultural worlds of physiotherapy. This has resulted in my approach not being one rooted purely in grounded theory, or being entirely inductive, but also containing elements of deductive thinking from the incorporation of that viewing 'framework'. In other words, having established the ideas that relate to identifications, structure and agency from an ethnographically interpretive approach.

I felt compelled to use some pre-existing framework of understanding in order to construct a view on these as there was no established means of approach to the topic of identifications in physiotherapy at the time of starting the research. I incorporate both theoretical and reflexive considerations from a basis in constructivist understandings to draw conclusions on the narratives (Kincheloe, 2001). Continuing to conceptualise analysis I incorporate critical theory, in order to generate comment in relation to the participants' cultural worlds. Details of this issue of theoretical underpinning is addressed in the next section.

In retrospect I naturally wish that I had done some things in the project differently and I shall consider this more in the final chapter. But here, looking back on events, I am able to see my journey as one of (relatively) linear development, and this is how I present it with the aim of generating clarity with regard to the final methods utilised and described in Chapter Four. I consider first the means of analysis and then I consider myself in this process.

3.2 Issues in Narrative Analysis

Different research styles overlap to an extent. As Denzin and Lincoln (2008) suggest, it isn't always easy to say if qualitative research is actually true to a certain form since there are many justified forms of the different research styles. This methodological flexibility is a fundamental strength of qualitative research; it allows the researcher to be innovative within their research whilst embedding aspects of the research derived from the practices of others and shaping the research to the context in which it exists. It would be true to say that this project has flexed quite a lot during its progression, with the troubling aspects of this study rooted in the complexities of the identifications given, received and shared by the participants and the challenges this creates to 'see' and draw meanings from their narratives. Here I address both theoretical and personal challenges to describing the participants' words.

3.2.1 Initial Engagement with Phenomenological Description

I started this research wanting to look at the meaning of a PG physiotherapy programme of learning that Indian physiotherapists undertook in England. But that meaning can be constructed in different ways. Phenomenology was attractive, since it focused on the caring aspect of human interaction between me as researcher and them as participants and chimed with my tutor role. This approach is fundamentally about respect, non-marginalisation and sensitivity to the power imbalances within the research context. The key problem with this approach was that in addressing questions of programme meaning, I required the participants' understandings of a construct (professional practice), not just their feelings towards it. And through my questions the participants described the meaning they had made of the content of the classes they took, largely omitting how it made them feel. Phenomenology became too personally focused for the shared working identification perspectives I sought. Initially I had rejected grounded theory methodology, partly because in the past, grounded theorists had been accused of viewing participants in research impersonally, as sources of data. Collins (1998) discusses this as a lack of sensitivity in this approach to data collection and I was committed to respecting participants as an ethical principle, but also consequent to an awareness of all the colonial history that persists between England and India.

Dewey suggests that education aims to 'release the human potential for growth' (Garrison & Neiman, 2003, p. 28). This broad definition offers a much wider scope of recognition for holistic, personal change through study. And accepting that learning releases human potential also drives a desire for an emancipatory approach to the research planned. However, because of power differences that are intractable, it is very difficult to simply access participants' ideas in the context I was researching. Initially cautious of interpretation, I rapidly found that there was no other means of viewing their narratives. There is a tension between social science theory and social justice theory regarding my research with students. I recognise that they are relatively powerless in the situation that they are in, but how can I as a tutor ask students to emancipate themselves from the course? They are caught in English education and culture, and to a similar extent I am too.

Phenomenology in a pure form is descriptive, but I was interested in meaning and what participants say about practice in comparing one with another, English and Indian practices, in discussing this 'in between' arena, thereby outlining either side. The research focusses on process or action, such as treatments and I become, not an active listener, but a participant in the research which is grounded in what the participants and I co-construct. And so in this way, the research took a critically and ethnographically informed approach to discuss the meaning of the views the participants expressed. Ethnographic because the discussions are rooted in culture and context. Critically informed because the results point to a need to disrupt the normalised, and I suggest unintentionally prejudiced, practices and call for change.

So having realised what the methodology was not, I progressed to an analytical approach that was interpretive. I use a method that is very like grounded theory, but the issues of theoretical sensitivity that limit the claims I can make on this as a methodology and I explore this next.

3.2.2 Theoretical Sensitivity

Grounded theory is a methodology that constructs theory from ideas that emerge through repeated viewings of narrative data. It forms a structured approach through which these emergent concepts can be developed and further theoretical frameworks applied and extended (Charmaz, 2000). Essentially it is an inductive process, but since research methodologies are socially constructed, grounded theory research has necessarily developed over time to include greater or lesser degrees of existent theory. A key development in the theory occurred through Charmaz (*ibid*). She suggested that, rather than being an objective observer (as in the more classical form of the method exemplified by Glaser (1978)) the researcher forms part of the research and brings ideas and prior understandings to it. So, rather than trying to have no preconceived ideas (Glaser & Strauss, 2009), I acknowledged both the ideas and the person I am as important understandings of context (Charmaz, 2000). Understanding that I am a co-creator of meaning making was an important step in accepting a constructivist form of research as an epistemologically

appropriate means through which I could unravel the complexities of analysis. It allowed me to engage reflexively in recognising multiple realities and perspectives, note how these shifted during the research process, as well as acknowledge employed theory and the disparate aspects of the research (Creswell, 2013).

Tensions are generated in terms of maintaining openness to theory and the drawing of conclusions. Charmaz (2014a) suggests that a way to resolve these tensions is to retain an open mind whilst analysing. This sounds simple, but given that analysis is multi-staged, Weed (2009) for example, discusses the distinct stages of description and conceptualisation in analytical processes) then generating methodological clarity about what theory is drawn in, and when, is challenging. Constructivist grounded theory generates a great deal of flexibility in terms of the incorporation of theory (Strauss & Corbin, 1997) as the level to which one brings other research and ideas into analysis generates the potential for different approaches.

Qualitative research can contain deductive processes (Hyde, 2000) and in my own approach I see that I used the understandings of culture and identifications very much as a starting point to help me understand and begin to interpret the participants' narratives. A key research aim was looking at the impact of two cultural worlds, notwithstanding the multiplicity of these worlds to both the participants and me. Holland et al. (2001) offers a framework for seeing expression of agency in terms of the creativity that results from the meetings of cultural practices. She and her colleagues cite an example of a Nepali woman who, due to low status, unable to cross the threshold when invited by a white woman researcher to an upstairs room of a house owned by a higher class family, climbs up the outside of the house in order to fulfil her obligation (and her desire) to be interviewed, whilst not breaking important cultural traditions. This perspective permits 'newness' (or agency) to emerge from existent forms of practice.

However having such an *a priori* lens contradicts the claim of grounded theory as a methodology for the research. It fundamentally challenges the inductive impulse of this methodology, since this inclusion generates a deductive approach, something general that I am applying to the data. For this reason I do not describe my research as grounded theory, as whilst constructivist grounded theory permits some prior assumptions (Charmaz, 2000), it would be over stretching the flexibility of the approach to incorporate a complete theory into the analysis in the way that I have and still name it as such. The deductive approach can be seen in Chapter Five as I discuss agency and structural issues. Also in Chapter Five, are considerations of practice, power and symbolism all of which I had little conception of prior to analysis. Here I use theory from Bourdieu around cultural capital, (Bourdieu, 1986a) and ideas relating to symbolism in practice from Geertz (1973) to theory build a new 'engagement' theory of practice for physiotherapy. Chapter Six goes on to apply the narratives from the perspective of critical race theory and Sennett and Cobb's (1973) considerations of negative self-image. So In the next section I explore why this approach was appropriate for me, then.

Influenced by Holland et al. (2001) and other social science writing on identity, including Giddens (2013) and Edwards and Usher (2008), I have developed a constructivist perspective of physiotherapy practice, which means that it is not something static and absolute as in a traditional European epistemology (Edwards & Usher, 1997). I see it as context specific, social and dynamic. This perspective chimes with my experiences of personal changes of practice in different countries and at different times. Incorporating Holland et al.'s (2001) perspectives of culture permitted me to sustain a way of viewing the meeting of different ways of being a physiotherapist which were present in the participants' identifications. In some ways the lack of existing literature around issues in physiotherapy conceptualisation, combined with my experiences as a researcher, meant that I took these aspects with me into the description, where another researcher would have been content to 'bracket' theoretical perspectives to a greater extent than I was able (Tufford & Newman, 2012).

3.2.3 Resisting 'Speaking For' Participants

My theoretical perspective has flexed from the proposal to the analysis. Indeed, in the early stages of the research, data collection occurred in a state of flux, where the flexibility of a constructivist approach was challenged. This situation arose partly because of the different context of the pilot study to the actual research and the results of this influenced my proposal heavily. The preparatory study had been designed, narrowly, to explore the 'active interview' (Kvale & Brinkmann, 2009) rather than analytical approach, and I had interviewed participants whom I had taught and knew quite well who were working near the University where I was teaching. These participants described the racism they had experienced as alumni living and working in England and my sympathy for the participants and their position as 'outsiders' in the English health care and social systems was strongly evoked. It also left me anxious to not interpret participants' narratives as, in doing so, I felt I would be speaking for them, and running the risk of reproducing oppressive power dynamics that they were already amply subject to. The commitment to the participant's voice, the enthusiasm to hear their story and the empathic immersion that this research style demands all appealed strongly to the anti-oppressive stance that I was motivated to utilise (Husserl, 1970). I enjoyed the narratives I heard, regardless of my questions or their answers, and it is clear that my personal style and life experiences influenced my initial adoption of phenomenology (Wertz, 2011). Looking back I can see that I responded to the emotionality of these interviews, both of the participants and me, by adopting a methodology and methods that could incorporate it. It can also be seen that the pilot study findings opened my view of their life stories and sensitised me to seeing structural oppression as a consequence of the participant's national identity.

However, the participants in the pilot study were better known to me and answered more fully and shared more emotionally than I had appreciated at the time. In the main research some of the participants and I had much less prior contact. So, while their interview data was rich in experiences of working, their responses to questions exposing practice were largely lacking in personal engagement or emotion. Phenomenology was less easy to see as relevant in this context, and with the lack of immediate participant experience data, but

plenty of ideas on professional constructions, I began to recognise and reflect on how interpretation was both essential to and inextricably bound to the research. The participants were not familiar with social science views of practice (given the professional history of physiotherapy outlined in Section 2.4) and their narratives demanded at least some reconfiguration in order to present their empirical perspectives into practice constructions. Interpretation of data is possible within phenomenological research, but the lack of relationship to this and them personally, and the focus of the research question on identifications rather limited the free and imaginative analysis that phenomenology encompasses (Wertz, 2011). Additionally, individual analysis was not the only interpretive act: once the meanings of practice were established I aimed to generalise and unite perspectives and make suggestions not only about Indian, but also English physiotherapy practices, as I sought to establish broader social meanings of physiotherapy practice.

However, if analysis is undertaken in a transparent and equal way, where my thoughts and stances are open to the same analysis and scrutiny as participants, then interpreting need not be a disrespectful (Lincoln, 1997). Indeed, undertaking the research in this manner would make the analysis less prone to patronising suppositions. Viewing the process in this way I came to see that analysis need not be oppressive, as I speak for the participants (Wertz et al., 2011). I think the inclusivity that I strove for in phenomenology can still be seen exerting an influence in my analysis. It is in this way that the concepts of fairness and justice are conceptualised at the outset and are held fast. Having realised this, it is interesting to note that Strauss and Corbin consider Charmaz's form of grounded theory to be a "hybrid" version of methodology, one that crosses with phenomenology (Strauss & Corbin, 1997, p. 35).

The recognition that phenomenology was perhaps a little self-indulgent on my part and not the optimal approach in this context probably accounted for the difficulties encountered in letting this approach go and the time taken to find a suitable alternative. But accepting that interpretation is essential meant that I could move to a research approach where it is a necessary activity rather than tolerating it. An advantage for this understanding is that theoretical ideas

aggregate from (or are 'grounded in') the gathering of data and its continued viewing (Glaser, 1978). This shifts the focus from researcher to the researched and, given the limitations of previous research into cross national education and the easy entrapment into colonialist thinking (see section 2.6), this can be seen as an essential position to take. Having considered issues of description, I now address issues of conceptualisation: the generation of meanings from the descriptions.

3.3 Issues in Conceptualisation

Having established a lens through which to analyse my data, the final interpretive approach regarding the meanings and conceptualisations of the analyses took a different form. Here the continuing interpretation of practice was generated by continued reading and thinking. Whether my sensitivities to issues of power and privilege were gained through the preparatory reading for the project and honed in the pilot study, or whether they were generated from the descriptions encompassed in the narrative data is hard to say. It is likely that both occurred. Certainly student focussed perspectives primed me to take a critical stance towards the results in Chapters Five and Six. These then focussed on the means of viewing expressions of power and authority, notably through cultural capital theory (Bourdieu, 1986a) and the symbolism of action found in anthropological literature (Geertz, 1973). The conceptualisations of pedagogic aspects were gained from understandings arrived at through critical race theory (Delgado & Stefancic, 2012). This so resonates with my thinking in relation to the results that I have used this perspective to elaborate on ideas relating to course pedagogy in Chapter Six.

Approaching the research in a constructivist fashion means that I am challenged to justify undertaking it within the context that I teach and this is impossible from an empirical understanding of researcher 'neutrality'. To generate the critical challenge necessary for deeper enquiry, an awareness of self is necessary and much qualitative research refers to reflexivity as part of the research process (Bolton, 2006). Here I consider my thoughts on the cultural issues relevant here, of how I view the participants as well as the

course they took - given who I am. This cultural awareness resides in my own position in the research, my attitudes towards participants, my attitudes towards me and the course I taught on. Again issues of 'self' arise with regard to conceptualisations, although in a slightly different form. It is these I consider next.

3.3.1 Positioning the Self in Research Practice

My exploration of how I, a white, middle-class English national, engage in research with the participants from an ex-colony of the UK, has been informed by theoretical perspectives of identity, identification and culture. As identifications and structural considerations emerged, participants commented not only on practice issues but also pedagogic themes. Equally pertinent, therefore, are questions of my position within the research arena, and being critical of it.

As a researcher I am very aware of being culturally different from the participants. However Myles and Cheng (2003) showed how difficult it can be when researching co-nationals (see section 2.6.2) and this makes my approach as a white, English researcher interviewing Indian participants no more intrinsically difficult than any other combination of characteristics (Humphreys & Brown, 2002a). If this were not the case, then the participants could only be legitimately researched by people of identical gender, culture, class (or caste), socio-economic status and so on. Patently this is not possible, nor is it even desirable as it has been suggested that the greater the difference between peoples, the greater the care around issues like justice and legitimacy of voice (Pearce, 2007). So, rather than argue for a static approach to any identification that might ultimately result in the argument that only Indian people are able to write about Indian people, I have tried to be flexibly aware of the many identifications that they, and I, bring to the research process.

Being a tutor presents challenges for me as I view participants through the sharing of our identifications during the research (Giddens, 2013). Chapter Two demonstrates that abuse (or merely the lack of recognition) of power relations

form a critical element of the research and once aware of these issues, ethically they cannot be ignored. Self-awareness and consistent questioning of personal values are more important than the striving for a false sense of distance from the participants researched (Fontana, 2002). So, in many ways, my teaching presence on the MSc programme has been an advantage in that I have taken with me knowledge of the programme and of the kind of learning experiences participants would have encountered within it.

Research in educational arenas should be based on an understanding of the positionality of all the cultures within the research context (Harré & Langenhove, 1991). Sustaining a participant centred approach, I accepted their identifications of the different cultural locations as part of their cultural constructions and this appreciation of their global mobility and relative importance within their narratives formed part of the analysis (Novelli, 2006). Section 2.3 wrestles with the definition of 'culture' and it has been shown to be elusive as there are no definite social rules of engagement that determine precisely how people behave, but in this context the issue of the location of culture looms large. When culture is sought through its expression by individuals, it emerges with all the attendant complexity of social and individual constructions that act on and through people. It cannot be denied however that individual acts are generated by 'something' social, hence the use of the term by Holland et al. (2001) of 'cultural worlds', allowing for a notion of social structure that does influence behaviour. In this research I am able to identify both English and Indian cultural worlds through my engagement with identity constructs. The interviews contained a mixture of cultural practices and these were presented as 'I used to' or 'I now'. In addition they contained aspects that are not recognisably Indian or English but something new. These are ideas about practice that emerge through the creative agency generated from the mix of cultural worlds and are expressed as 'I'm going to'.

3.3.2 Reflexive Awareness in Pedagogic Practice

In my research I viewed not only Indian participants but also, through the identifications they gained, the course that sustained them. My presence as

researcher in practice can only be sustained by careful reflexive consideration and this is demonstrated as I present the findings. My reflexivity forms an important ethical principle as I critique the teaching world of which I was a part and stands as an aspect of legitimacy in the discussions I offer. My presence as researcher impacts on the results, first because of the shaping of the discussions participants presented to me as students on the course on which I taught, but then again as I interpreted what they had said, continuing on into the analysis and interpretation of the results, through my capacity to pay specific attention only to what I recognised as existing within practice. This represents a double hermeneutic (Giddens, 1984) of sizeable proportions (a quadruple hermeneutic?) as I seek to understand them understanding me, in teaching and learning; participating in my research and undertaking it.

Embedded in the research as not only a researcher, but also a tutor, these dual perspectives have given me an opportunity, notwithstanding the difficulties outlined in hermeneutics of seeing issues through the eyes of others, to see just glimpses of the course in the narratives of the people who have experienced it. Contained within their descriptions of practice and the meanings they made of the course content, were messages about how those ideas were disseminated and transmitted. So, as they spoke to me about the constructs they had learned from the educational experience they had been exposed to, they revealed the course anew, offering me a way to see differently the teaching in which I was involved. In some ways this foundation for the research and my encapsulation within it has been a considerable advantage. I knew the programme intimately as well as the tutors and teaching approaches within it. However this has also created disadvantages, notably around potential difficulties envisioning that beyond what I already perceived. These areas of 'blindness' for me as a researcher exist as a weakness in the research and Weedon (2004, p. 2) has referred to these difficulties as the 'taken for granted' aspects of viewing cultural worlds. This is in large part because of the invisibility of structural issues, but in physiotherapy this might also be rooted in the positivist perspective of physiotherapy practice and its general lack of cultural (and therefore self) awareness.

The perspectives on teaching practice were the last to emerge from the data, and the difficulty of seeing the pedagogic, when it forms the immediate context of the research is almost strange as I look at it now, as it represents in many ways a more tangible cultural world. This is perhaps because this focus reflects my influence and interests in the interviews, with my attention focussed on the immediate and central issues of performance constructions. Paradoxically then, for professional programmes, given their focus on the professional, the pedagogic meanings that underpin them and the cultured worlds that envelop them, are more hidden. The mechanism to address these issues is rigorous reflexivity, to sustain an openness of thought, which is why I have returned to these matters once more, as part of this chapter's considerations.

3.3.3 Cultural Sensitivity

Some of my difficulties around analysis in the early stages were rooted in my anxieties for participants, of not wanting to merely 'pillage' in relation to data collection (Collins, 1998). To ignore the unpleasant or negative in the results would be to contradict the principle engagement with power discourses previously discussed. So, having recognised issues of cultural dominance in teaching, I cannot then ignore them. This forms an ethical principle consequent to an awareness of the colonial history that persists between India and the UK. Having identified a form of cultural domination, whilst I am uncomfortable in appearing to criticise the course, I am required to address this directly. And it should be remembered that any criticism I make is also levelled at me too, demonstrated through my own reflexive analysis of my recognition of cultural inflexibility and English centricity.

I am also aware that students may not agree with my analysis, and this could be the reason why participants have not responded to the results I shared with them. However these results are a combination of my voice as well as the participants. Here, as researcher, I carry the interpretive burden and the ethical duty of reporting findings. This is what I view them as meaning, even whilst they may not agree or feel able to agree. On these grounds I present these interpretations as my own, even whilst they are embedded in the participant

responses. Additionally Baxter and Eyles (1997) suggest that logicality is a requirement of qualitative analysis and, though this is a term that could be debated, my working understanding of it is that the results should align in some respect to what is already known about this area.

The discussions necessarily focus on the professional culture of physiotherapy as represented by students taking part on one specific MSc Physiotherapy course at one specific English university in the academic year 2012-2013. The generalisability or representativeness of these results becomes an issue and form another aspect of the discussion relating to the location of culture. I recognise that it would be easy to make grand and unjustifiable claims for six participants discussing one programme, in one year, focussing on just one semester of study. Having said that, the university is located in England and its teaching reflects English practices. The undergraduate programme, from which the MSc extends, is ratified by the national professional registering body, indicating certain homogeneity of content with the rest of the UK and so further analysis may continue as the results are shared and further explored by other practitioners. The course teaching reflects UK practices and a balance needs to be struck between reducing the meaning of participants' comments to the point where they say nothing at all, and 'over blowing' the results to make extreme claims about cultural supremacy within the whole of physiotherapy education. Although I have a very limited data set, the issues I see are shared in other teaching environments (Sheridan, 2011). This is where the logicality required of Baxter and Eyles, (1997) comes to light once more – cultural dominance is a common issue in teaching (Palfreyman & McBride, 2007) and it's prevalence, as well as its impact, relates to the difficulty we all have of seeing our own cultural worlds, just as I struggled when working in Birmingham to see mine. Seen in this way transferability of the analysis undertaken here is not something that is contained only within this research, but instead is part of a wider process. Ultimately decisions about the usefulness and meanings of the project lie beyond it, within the engagement with it by others.

It should be remembered that students were generally very positive about the programme. Although I might remain sceptical of their need to present

themselves in such a way to me, in order to remain true to their voices, my analysis needs to present a balanced view of both negative and positive teaching issues, as well as how the consequential issues might be viewed or acted upon. There are other hidden presences that I represent in the programme and those are of the tutors. I am aware of my role with them in the programme and for this reason I have sought to make the location of the programme hidden within this thesis. Anonymising the research site allows for an expansion of thought, no longer restricting these issues to the university in which the research was located, but encouraging it to be a consideration applicable to any institution. Ultimately the balance between claiming too much or nothing at all is one that must be held within the reader's mind as much as in my own.

The acceptance of other cultural views is a legitimate concern for us all and the issue of whose knowledge is accepted is very much to the forefront of consideration in critical race theory (CRT). CRT suggests that racism is normalised through social structures (Gillborn, 2006; Ladson-Billings & Tate IV, 1995). It suggests that systems of knowledge tend to produce knowledge from their own frame of reference, based on the social, historical, cultural and political history of the dominant race. This acts to negate the knowledge of others and sustains and justifies oppressive practices and attitudes. Appreciating this theory has formed the final stage of my understanding of the meaning of student learning, and the last part of this research journey. Much of my early reading prior to the project was about the potential for these issues, then in my research analysis I recognised them. As part of a search for understanding using grounded theory, CRT permits challenge and change to established orders. There still remains a tension between CRT and grounded theory, in terms of theoretical sensitivity, but in finding such a rich vein of established writing that explores the raced viewing of others it seems to be to be a helpful construct to incorporate into thinking. In the next section I rationalise the focus I have taken on the particular cultural identification of Indian.

3.4 Focus on Indian Physiotherapists

At the proposal stage I presented a pragmatic desire to study Indian practitioners as they formed the largest part of the international student cohort and would be easiest to recruit. But the choice to study Indian therapists partly also grew from my own interest in this country context. The university had an ambitious recruitment policy for international students and I formed part of the recruitment team and travelled a number of times to India and South East Asia between 2008 and 2012. My work in India and with Indian people; with students in my professionalism module and assessment of dissertation projects undertaken in India, all contributed to developing my interest in Indian practice to the point where I undertook a study visit to India. This was not officially part of this research, but something on which I drew extensively as I progressed through the project. The two week trip in the summer of 2012 on a funded travel scholarship from the United Kingdom and India Education and Research Initiative[12] allowed me to work at a hospital in Karnataka, in South East India. I travelled to work with an Indian colleague, the Head of a Physiotherapy Department who I met at a World Congress of Physiotherapy conference in Mumbai. I worked with academics and clinicians during this time and engaged in critical discussion about practice with them in order to develop my understanding of physiotherapy practice in India. As Fine (1994) suggests, one's sense of self is formed when you compare yourself with another and I think my capacity to view how practice is grounded in context and invested with meanings was facilitated through this visit. It should of course be remembered that India is a vast country and contains wide variations in practice and resources, not least in physiotherapy, but this trip was still useful in offering me some limited sense of working conditions there. It allowed me to observe practice in a small teaching hospital, an opportunity that enabled me to more fully understand Indian working concepts, however narrowly.

Perhaps the decision to concentrate on a single nationality was also informed by static ideas of culture and my perceived ideas of 'Indian-ness'. Entering into discussion and analysis however really challenged this stance. My assumptions were further questioned as I read more widely during the analysis phase. I

[12] UKIERI: a government funded initiative, instigated to improve UK-India trade relations.

recognise that every individual, everywhere experiences life differently even with the homogenising aspects of 'culture'. They would, therefore be likely to experience M level study differently. Nationality as a reference point has its limits too, as participants, while identifying as 'Indian' were frequently brought up in one place, studied in another, travelled to work widely and have close family members all-round the world. Notwithstanding this however, when considering cultured worlds, students from one country will have shared at least some of the same structural issues and so addressing a single nationality has formed a helpful approach through which to consider these. There may be 'no such thing as culture' (Mitchell, 1995), but structural issues are ever present (Holland et al., 2001) and there are shared frameworks of understanding these that can be recognised as culture (see section 1.6, pg. 37). The term 'Indian' however belies both the complexity, and the location, of the cultural web of influence in which the research took place in.

3.5 Chapter Conclusion

Whilst rooted in an analytical process embracing aspects of grounded theory, with the use of this as a fundamental theoretical perspective, my analysis is ethnographically interpretive. As a social science researcher, I am aware of the power relationships that exists between the participants and myself and these issues influenced my decisions about how perspectives are situated and privileged within my study (Fine, 1994). How I am positioned and how I view the participants, and the ethical decision making this generates, forms part of all aspects of this social science inquiry (Madden, 2010). Dealing with the tensions around my presence(s) in the research was a particularly troubling aspect for me. As a consequence I have felt the need to integrate explicit, existent theoretical understandings into the project in order to help me establish perspectives on identifications and cultural worlds. As a result of this both the phenomenology and grounded theory approaches that I have attempted foundered on the inclusion of pre-existing framework of understanding; phenomenology because of the interpretation using such a framework demanded, and grounded theory because of the limits to induction it permitted.

Atkinson and Coffey (2003) describe research simply as labouring towards identity and recognise that different identities are both required and performed by me as a researcher. Add to this my own role within the university hierarchy, with a job description that makes me responsible for the international student experience within the health faculty, then the pure neutrality of 'understanding' as previously espoused can no longer be claimed. 'Knowledge is power' (Hall, 2001) and I recognise my need to be aware of my own gains through undertaking this work, and the discourses to which it may align. A critical framework has allowed me an understanding of specific issues, the conditions that serve to disadvantage and discriminate against cultures, such as hierarchy, hegemony and racism. Students can be seen to be exposed to white authority, in the form of an English University, and its promotion of hegemonic Western practices.

In this chapter I have offered the theoretical and personal underpinning of the approach I have taken toward my research. I am now able to now describe my research methods and demonstrate how the methodological stances described here were applied to this project context and to the collection, processing and analysis of the interview data.

4 Chapter 4. Methods

Here I provide detailed information about the methods used in the research project, including my role as researcher. I explain how I recruited and interviewed participants and how I undertook the transcription and interpretation of their narratives from recordings. I detail the ethical practicalities for undertaking a research project in a university, but I also show how I addressed the ethical sensitivities that are fundamental to the performance of the research.

4.1 Introduction

Chapter Three outlined issues around the shaping of the research methodology. In this chapter, I outline my approach to their practical management through a description and explanation of the research method.

Ethical issues arise as an inevitable consequence of a number of conceptual complexities. These include my role within the university as lecturer as well as in student support, which could create confusion among participants with regard to the purpose of the research; the vulnerability of participants at this stage of their MSc; the lack of evident intrinsic benefit to them from participating in the research; the relative power relations between us and a probing approach to interviewing. Such issues are common for practitioner researchers (Drake & Heath, 2010) and Section 4.2 addresses the procedural management of ethical issues but, given the inherent ethical dimensions already expressed and fundamental to the project, I also interweave these considerations into the rest of the text as necessary, rather than leave ethics expressed solely as an external factor to the project (Patton, 1990).

I attach a Gantt chart in the form of the research time line on the next page:

Table 1. Gantt Chart – Research Time Line

Activity				Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	March 2012	April 2012	May 2012	June 2012
Pilot study												
Pilot study write up												
ED 1 and university ethics preparation												
Preparation and planning												
	July 2012	August 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	March 2013	April 2013	May 2013	June 2013
Preparation and planning												
ED 1 approval and university ethics												
Recruitment for interviews Sept 2011 cohort												
Interviews and data collection Sept 2011 cohort												
Recruitment for interviews Jan 2012 cohort												

Activity	July 2012	August 2012	Sept 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	Feb 2013	March 2013	April 2013	May 2013	June 2013
NVivo training												
Data transcription and first stage analysis Sept 2011 cohort												
Interviews and data collection Jan 2012 cohort												
Data transcription and first stage analysis Sept 2011 cohort												
Interviews and data collection Jan 2012 cohort												
Phenomenological approach attempted												
Activity	July 2013	August 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	March 2014	April 2014	May 2014	June 2014
Data transcription and first stage analysis Sept 2011 cohort												
Interviews and data collection Jan 2012 cohort												
Data transcription and first stage analysis Jan 2012 cohort												
Completion of transcribing												

Activity	July 2014	August 2014	Sept 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	March 2015	April 2015	May 2015	June 2015
Writing first draft												
Writing second draft												
Completion of all stages of interpretation and analysis												
Activity	July 2015	August 2015										
Critical readers input												
Layout and text checking												
Submission												

4.2 Formal Ethical Processes

The project was submitted and approved by the University Ethics Committee prior to commencement (see Appendix 2 for the approval letter). During the research I adhered to both the ethical processes sanctioned by the university and the British Educational Research Association Guidelines (BERA, 2011). Volunteer participants were given an information and an advice sheet before agreeing to take part and were given sufficient time, without pressure or duress, to decide whether or not to proceed. They signed a consent form (see Appendix 4) which gave the option to withdraw from the research at any time, stated the time that interview material would be kept and assured participants of confidentiality. I explained the limits of confidentiality (in situations of conflict with my professional role for example if they disclosed evidence of abuse or academic malpractice) at the start of interviews, I made it clear that I would inform them during the interview if a participant had begun to trespass into an area that would have been improper for me to conceal at this time. DiCicco-Bloom and Crabtree (2006) recognise the importance of interviewee information protection and all participants in the study remained anonymous to everyone apart from me and those required to have access as part of academic or research governance processes.

To maintain anonymity I recorded all interviews on my personal digital recorder and downloaded and stored recordings and transcriptions safely on the password protected university general drive which was 'backed up' daily in my own 'Identity Project' folder. Only I had access to this folder, and it formed my research site file during data collection. I downloaded material onto a password protected, encrypted USB stick which acted as a transfer device between my home and work computers. On leaving the university, the entire site file was transferred onto the same USB stick. Only the anonymised data required for analysis and transcribing was retained on my home computer hard drive, to which no-one else has access. It contains no identifiable personal information so that, in the event of the computer being stolen, there is no risk of breach of confidentiality. I encouraged participants to choose pseudonyms for the interviews so that they would be able to recognise their words in my analysis, but remain anonymous to external readers.

It was also important to guard against more subtle breaches of confidentiality into academic and social arenas. None of the information I gathered influenced in any way any academic board for the student participants involved. When I met participants incidentally around the campus, between the interviews, I was careful to always greet them as I would any other time, so as not to reveal to others that I had any dealings with them beyond the course. I negotiated appointments only by email to avoid casual overhearing by other students or staff.

Having detailed the formal processes of ethics, I now explore further ethical issues in relation to other key aspects of the project.

4.3 Managing Multiple Researcher Identifications

Part of a constructive resolution to managing multiple researcher identifications was to interview the participants towards the end of their MSc programme, when they were working on their dissertations. At this point they must have achieved all taught credits, received all feedback and have material with which to engage and consider without the need for a great deal of tutorial support. They all had named dissertation tutors and my engagement with them as a tutor was largely in the past. I ensured that I was not involved in formal university assessment processes accorded to participants' dissertation projects, so as not to disturb the student-tutor-researcher relationship further. At this point in their studies, I was able to use the advantages of having an understanding of the learning process participants had been through as well as some of their own journey within it, without confusing or compromising them or myself.

Indeed their participation in my study could have acted in a supportive way towards their own development as qualitative researchers. Students often find themselves having to undertake qualitative projects due to ethical constraints protecting patients, despite the profession's alignment to more quantitative methods. This potential support provides a further rationale for engaging with participants towards the end of the programme, since it occurred at a point when they had more to gain and it is proper, according to Bolton (2006), to

consider knowledge in political solidarity with the more marginalised members of any research context. Additionally, opportunities to reflect at this point are likely to be more helpful for participants, particularly as they prepare to return home. Ultimately it was not possible for me to determine what their motivation for taking part was, so I made sure that their agreement to be involved was un-coerced. I explained what the research was; what I saw their role as being and allowed them space and time to consider their wish to be a part of the research.

Participants had the ethical right to understand the research and their engagement with it. In this way my role also related to informed consent. I anticipated that participants might have felt differently as the research progressed so, in addition to signing the consent form, I asked prior to the second interview if they wished to continue. I reminded them that they could discontinue their part in the study with no impact at all on their studies or graduation. Any student who wished to withdraw could have done so at any time and all data would have been removed up until transcribing was completed - no more than 6 months post interview. By this time however their results would have begun to have been analysed and whilst I would have still removed all data, some of the annotations placed in NVivo relating to their words and ideas might have remained.

My approach to managing my dual tutor/researcher role in the interviews was influenced by feminist theory as expressed by Kvale (1996). He suggests that researchers should consider their 'demeanour', not in a prescribed format, but instead respond to what is required by the participant. To this end I tried to be alert to the participants needs; many had questions about the future, further study, or their research project and I either made separate appointments to discuss these with them or I answered them within the interviews, depending on the breadth of answer required. During the interviews I tried to maintain my researcher identification as much as possible. If I needed to change roles, I tried to communicate this by prefacing speech with 'as a tutor…' to try to make clear the role and the boundaries that I was working to and establish new parameters and boundaries to those new conversations.

There was also the potential for participants to be involved to a greater extent. My original intention was to share interview transcripts with participants to enable them to comment on their 'correctness' or add further comment. I did share the first interview transcripts, but due to my methodological struggles and uncertainty regarding the meaning in this process, in depth analysis took longer than expected. I abandoned sharing the transcripts as this appeared to be of high inconvenience for the participants and little value to either them or me. However, I wished to include participants in the data analysis since my approach was determinedly inclusive and because of the issues around cultural imperialism already outlined. But I also needed to appreciate that participant engagement needs to be couched in ways that reflect their capacity and willingness to be part of the process, rather than expecting an academic commitment for a task that they are generally unprepared to undertake. Instead I contacted all the participants via email to offer them the completed, but condensed, analysis for comment. Sharing my conclusions in this way not only met an ethical obligation, but it also represented a more appropriate view of participant participation. Additionally, it gave me the opportunity to thank participants for what I felt I learned, as well as celebrate with them their development and progress during the course. Interestingly none of the participants responded to my approach, and this is addressed in Chapter Six in the light of a fuller analysis of the results.

I have remained in contact with all the participants via Facebook since the end of the data collection phase of the project and have been able to see their lives develop and change. All 'friend requests' came unsolicited from the participants themselves; in all cases once they had left the university. While this does not form part of the research, it does reflect my ongoing professional engagement as a tutor of physiotherapy. I recognise that all communication helps form my perspectives and I have tried to not allow elements of these interactions into my research analysis since it is beyond the scope of their consent.

During the interviews I established a non-directive role, but outside the research arena I exchanged emails about a number of issues with participants (family and study issues and one research project). Students miss their family when

they move to the UK. As a consequence of the empathetic and listening approach of the research interview, participants did turn to me for emotional support on occasion. This could have blurred the boundaries in terms of how they viewed my role, but I focussed the research away from these issues and did not discuss them within the research interviews. However, I did remain aware of this as it forms an aspect of the tutor persona (identification) that I have.

I have other identifications within the research and that is of colleague to other tutors on the course. During analysis it became clear that much was being implicitly said about the course and the way it was taught. I have anonymised the university so that tutors on the programme cannot be identified, and what critique I offer of the course is in the light of my own struggles for cultural sensitivity, as well as understanding that what occurred in this research venue is not unusual and is probably replicated in different ways in many locations where well-resourced countries accept as students, nationals from less well-resourced countries.

4.4 Participant Motives for Research Involvement

Taking part in my research potentially presented participants with an opportunity for reflection and emotional support, as well as legitimising my engagement with their own studies, since I had no formal involvement with their dissertation supervision or marking. They may have also gained by seeing how I conducted qualitative research. All the participants were more relaxed (as, perhaps was I) in the second interviews. This may have been due to a number of factors: by that time they generally knew their results; they knew what would happen in the interview; and they were lifted from the tutor-student relationship somewhat by virtue of their having graduated in all but name. They also mostly knew what they were going to do next in their lives, an anxiety particularly present for some at the beginning of the interview process.

4.4.1 Participant Recruitment

To find volunteer participants I emailed the Masters level cohort via their cohort specific, web based teaching platform with an invitation to participate (see Appendix 3). Volunteers were sent the information sheet and consent form (see Appendix 4). Following their acceptance of the research terms and conditions, I arranged an interview meeting through email and booked (different) rooms on university campus for the purpose of meeting and recording the interviews. The first interview took place in October 2012 following successful project proposal and ethics reviews over the preceding summer.

I interviewed six participants. I had originally planned to interview eight, and, although there was no particular attempt at quality or validity with this number, it was chosen to represent some acknowledgement of rigour in the results. However, from a constructivist perspective, participant numbers do not carry much meaning, since everyone is different. The six contributions have proved fruitful in terms of the depth and breadth of analysis possible (Wertz et al., 2011). Any rationale for involving more than one participant exposes the dangerous territory of potential idea 'saturation' (Glaser, 1978). Given that the results always reflect a partial and distorted glimpse of an individual, in this uncertainty of identifications, combining meanings must be addressed with considerable caution regardless of the number of voices. I wanted to speak to more than one participant as a means of exploring individuality as much as generalizability; six interviews each semester proved a manageable number in relation to my work load; and six people happened to volunteer.

4.4.2 Participant Profiles

The research began with three participants from the September 2011 cohort of the MSc programme and continued the following semester with three more participants from the January 2012 cohort. All were on the MSK route and all discussion relates to this area of practice. Four had come straight from qualifying from India and, as such, had only their 6 months internship as clinical experience to draw on. Table 2 outlines brief participant portraits to show their pseudonyms used in quotations, information that was useful to me in relation to

analysis, such as their English or Indian work experiences, and the extent of our previous contact:

Table 2: Participant Portraits and Pseudonyms

Pseudonym[13]	Portrait
Sue	September 2011 cohort. A single woman in her mid-20s, of Indian heritage, but born and brought up the Middle East. She undertook her Bachelors in Physiotherapy in India, then worked again in the Middle East, before coming to England. She took the professionalism module when I module led it and then acted as a peer support volunteer for the module (see section 1.4.2). We had much contact during this time and just afterwards and discussed issues that related to professional physiotherapy working a great deal. She also had a work placement locally during the course.
SB[14]	September 2011 cohort. A single woman in her early 20s. She studied in England prior to the post-graduate (PG) programme going directly from under to postgraduate study. She took the professionalism module when I module led it. She gained work experience in England during her undergraduate study, but also had a placement in India and at other locations in the Far East. She also had family in England.
Kevin	September 2011 cohort. A single man in his mid-20s, originally from the Punjab. He had been quiet in class and I had little contact with him prior to the interviews, only in the professionalism module which he took when I led it. He appeared enthusiastic initially, particularly about his dissertation and we discussed his analysis of his research data between interviews. Also between the first and second interview a family member passed away and he appeared low in mood during the

[13] Pseudonyms were chosen by participants (see section 4.2, p. 92) and the meanings that can be drawn from their choices are discussed in section 5.2, p. 116.
[14] Not her actual initials.

second interview.

Sam — January 2012 cohort. An engaged woman in her mid-20s, originally from Gujarat. Her mother had been born, grew up and worked in England, married and then returned to India only later on in life. Sam's family was widespread, with relatives living all over the world. Our only prior contact was in a few classes that I had taken during induction. She had a work experience placement locally during the course. Something that only emerged during our second conversation was that Sam had been ill during her course, something the University had been unaware of. Our final interview was held on her last day in England and she was clearly delighted to be returning home.

Kunjan — January 2012 cohort. A single man in his mid-20s originally from Gujarat. He worked in a private clinic in his home city for a year before coming to England, but did not have a placement as part of the course. Our only prior contact was in a few classes that I had taken during induction, he was quiet in class, and I did not feel I knew him well. At the time of interviewing he was continuing to study more modules than his dissertation. During interviews he was emotionally contained and I found his tone of voice and the overall flow of his words important in interpreting his meanings when analysing his transcripts.

Nick — January 2012 cohort. A single man in his mid-20s originally from Uttar Pradesh. He worked in a private clinic in his home city for a year before coming to England; he did not have a placement as part of the course. Our only prior contact was in a few classes that I had taken during induction. He was quiet in class, I did not feel I knew him well, and our exchanges revealed little of him personally as he remained quite formal in his approach to me. At the time of interviewing he was continuing to study more modules than his dissertation.

The first cohort participants were well known to me, as they had been taught by me on the module that I led. I was also academic and personal tutor for one and another had been involved with me in a student researcher project and we had extended contact through that time. In February 2012 I was off work for four months with a back injury and was unable to lead my module with the second cohort participants and so there had been much less opportunity to establish friendly relationships with this group. It took a little longer to generate volunteers from this cohort which at first I considered due to a lack of personal connection with me, but the impact of the Christmas break (when many students return home) may also have been a factor.

The research consisted of two interviews with each participant, one at the start and one towards the end of the dissertation process. Due to resubmissions and extensions participants were engaged in, the gap between interviews was around 7 months for the second cohort compared to 5 for the first cohort. My relative familiarity with participants is evident in the interviews: in the dialogues with the first three participants greater levels of personal disclosure and emotion are demonstrated on both our parts. However, given the focus of the research this did not impede the analysis; indeed the second cohort was perhaps easier because of the concentration on professional issues.

4.5 Conducting the Interviews

The interview narratives were the means of accessing the 'profound connection between identity and practice' (Wenger, 1998, p. 149). I developed an interview style to generate narratives that incorporated rich descriptions and views of practice (Kvale & Brinkmann, 2009). The two interviews with each participant functioned together, the first working to establish a research relationship and begin thinking about professional practice and learning on the course, and the second to return to, clarify and expand these ideas. My approach to and conduct of the interviews follow.

4.5.1 Approach to Interviews

Following the pilot study analytical process (or rather the poverty of it) I determined that following guide questions (see Appendix 5) too closely prevented me from actually hearing the resultant narrative so, in the main research, I employed a more open style of questioning and encouraged free-flowing narrative and dialogue, where I followed up on responses in a more natural way (Kvale, 1996). I still used a guide to prompt me when free flowing dialogue faltered, but I did not adhere strictly to the interview questions. The first guide was constructed after Coffey (1999) to generate a sense of identification. Questions were aimed at establishing an outline of the key aspects of self, our will (how we want something), what matters for our sense of worth (recognition) and what we long for (our desires). However after the first three transcriptions I realised that the link between the narratives and professional identifications were not obvious and so I added questions to focus more directly on professional identifications and how they expressed these to others (see the re worked initial interview questions in Appendix 5). I also had a slightly different set of prompts for the second interview (also in Appendix 5) aimed at expanding on the ideas already outlined in the earlier interview.

This approach necessitates close listening and conscious presence in order to gain the fullest sense of professional identifications, using the participants own words and constructs (Kvale & Brinkmann, 2009). Interpretation is also supported by this approach: by being able to take part in and think about the dialogue to a greater extent as it was happening, also allowed some initial interpretation during the interview rather than only afterwards and involve the participants in my developing understanding.

Each interview was considered to be a performance that unfolded as it progressed and which formed an opportunity for us to construct understandings – not merely to impart information (Fontana, 2002). During these interviews I focussed on the interplay between us, creating an environment where we were both learning (Vygotsky, 1978). I needed to listen carefully because, as I questioned, I trod a fine line between being challenging and explorative, but

also maintaining the values, well-being and dignity of the participants. This interpretively dynamic approach meant that meaning making acts were centred on my engagement with participants (Lincoln, 1997). In this engagement I tried to avoid the pitfall of speaking for the participants (Fontana, 2002) enabling participants to refine their own thinking on what they said wherever possible. I tried to approach this exchange carefully and incrementally, being sensitive to what they wanted to say rather than my desire to speak. For example, one participant felt that they should not continue with a line of discussion that had started and so I did not press for more details nor did I continue to interview when a participant appeared to have said all that they had to say. Nor did I press a participant who appeared low in mood: instead I shortened the interview and closed down the research element of our meeting, as to proceed may not have been in the participant's best interests.

I have already outlined the need for me to be self-aware in the research process, and the work of this reflexivity requires me as a researcher, ethically, to not project my own prejudiced and partial thinking onto the participants of my study. Equally, I should not view these participants in such a way as it becomes difficult to offer what might be seen as negative or critical insights into activity or attitudes (i.e. affect dishonest neutrality). By maintaining active consciousness through my research work I tried to voice openly and respectfully the fullest understanding I had about our discourses as they proceeded.

Furthermore, given the participants' lack of discursive familiarity with the concepts and cultural dominance which is the focus of my study, I was aware of the potential for confusion and sense of criticism they might feel. So I offered an opportunity to meet with them at a later date to explain and contextualise the results informally if they wished. None of the participants did wish this, but the offer formed part of my responsibility as a researcher. Any such meeting would not have formed part of my analysis, since it would have lain beyond the ethical permissions of the research.

I found it hard to both think in the moment in the interview and make notes and so I tried to capture my thoughts afterwards as post interview notes which I then transferred to my research diary, in order to assimilate these thoughts with those that occurred later during transcription (Tierney & Dilley, 2002). My research diary also held pertinent information gleaned outside of the formal recording of interviews. These largely reflected the wider perspectives on participants' lives - issues that might impact on my understanding of their attitudes and beliefs as shared in the interviews. For example one participant shared news of an upsetting family event just prior an interview and I noted this and their sadness as contextual to the interview. This information was useful in maintaining original, reflexive and creative thinking about situations over a longer period of time (Schwandt, 2000). During this time I began to consider and reconsider the early transcripts and recordings, I started to generate tentative theoretical categories (such as 'active' and 'passive' forms of approach in physiotherapy) and allowed these to shape both the second interviews with the 2011 cohort participants, and refined the questioning in the second set of interviews with the participants from the January 2012 cohort.

All but one interview occurred at pre booked locations on the university campus, wherever meeting rooms were available, and without glass doors, to reduce the likelihood of distraction. I placed a note on the door asking not to be disturbed, but this did not stop people from walking in on one occasion. The rooms were adequate, and did not present a barrier to the interview although one halted early due to cold. Some rooms were better than others for extraneous sound (doors banging, voices of passers-by) but the interviewees seemed less distracted by this than I was and there were no major disturbances in the interviews. The context of the interviews made my personal safety an unlikely issue and all interviews occurred without incident.

Developing a sense of professional identification is not simple and it is often contradictory, and these contradictions are not always immediately obvious. I asked no direct questions about identifications, since these function less well at elucidating ideas than those that approach the issue obliquely (Benner, 1984). I was very flexible in terms of the questions asked, the question length and my

responses in order to create space in which both the participants and I could express ourselves. Therefore the interviews were of quite varying lengths, ranging from 34 to 64 minutes.

One interview took place in a coffee shop in the city centre, on the suggestion of the participant for ease of access as she had a very busy schedule and was leaving the city to start work in a matter of days. This interview was a little truncated since I turned off the recorder at the end of the arranged interview, but we continued to have such a good discussion that I turned it back on again, with the participant's consent. The only other occasion when the discussion was breached was when the battery ran out. Fortunately I had the recorder in sight and I noticed within minutes, and very little of the discussion was lost.

It has been well established in the literature that international students can be very (di)stressed during their course of study (Simpson et al., 2009). My research extended over several months and, whilst it was towards the end of their studies, participants were undertaking their dissertation and working largely alone. This can be a time of high academic stress especially for those students who had not passed all modules. For others there were personal stresses or health issues, some of which I knew before interviews began while some emerged during the interviews, and no doubt, some of which I was never aware.

4.6 Transcription

I transcribed the first 6 interviews (3 participants) by downloading the material on a password protected USB stick to my home computer. I played each interview at half speed and transcribed it in 'Word' format making analytical notes (Boeije, 2009) alongside the text. I then listened at full speed to make sure that nuances were captured, further annotating as necessary. Where there were words of Indian origin I asked for clarification from the participants. I downloaded the text into NVivo (version 10) and any embellishments that had been made during transcription were removed from the text and inserted as annotations in NVivo. These annotations began the analysis and so it can be

seen that in this way transcription formed part of the analysis. I had intended to transcribe each person's interview before undertaking their second, but due to the time pressures, instead I listened to the recording of the first interview again prior to the second interview. This was not ideal, but it enabled me to sustain an approach that included initial interview analysis, and the use of this to deepen the second interview engagement.

My analytical approach to the transcriptions was that suggested by Dilthey, where I aimed for a 'practical understanding' of the meaning of the discussions (Miles & Huberman, 1994, p. 8). A comprehensive description of this approach is contained in Miles and Huberman (1994, p. 69-72). In some cases, due to the language used, reading the transcription alone would not make easy comprehension as the participant's English was non-standard. However understanding was made easier by listening to the tone and general direction of the narratives, to embrace the general meaning rather than the specific details of narratives. Clearly the language used adds to the ambiguity of the interpretation, but this is not only true for speakers of English as an additional language (Tierney & Dilley, 2002). For example, there were points when the narratives shifted between the participant and someone else, something I understood in our conversation, but appeared odd in a written format. Inevitably there was a sense of understanding the participants best during the interviews, which in this context enhances the need for speedy transcription.

Because of the richness and consistency these practices generate, I had decided to undertake all the transcribing myself. However immediacy and comprehensiveness are key issues in analysis too (Boeije, 2009) and I needed to progress to coding and analysing whilst the data was still relevant and contemporary. It can be seen from the project time line (see section 4.1) that the first group of transcriptions took 10 months to complete and, having collected the second group's interview data, I was in danger of losing memories of context generated during the interview collection. Work pressures meant that I was not able to manage the transcription alone in time to be able to analyse fully. I employed a fellow physiotherapist, who was not known to the participants, to transcribe the second cohort's interviews. She knew only the

first names of those whose scripts she transcribed in addition to their pseudonyms. The advantage of involving a physiotherapist was that she could understand both the words and concepts we were discussing, so that the flow of their narratives could be sustained (Seidman, 2012). There were one or two occasions where transcription was problematic and on the odd occasion where neither of us could discern the recordings - these words were left as spaces. The data was passed between us on an encrypted USB stick and the transcriber signed a confidentiality form prior to undertaking the work. On receiving the transcriptions from her, I listened again to the recordings and read the script to check for accuracy and made additions, corrections and annotations as I would if I had transcribed myself, thereby preserving the attention to detail.

4.7 Textual Analysis

As I began to analyse the interviews, isolating meaning from the text became a challenge. Using NVivo seemed to provide multiple options rather than a solution. In the process of breaking down the text, I found complex relationships between different ideas in a flowing dialogue, but equally in sustaining the narrative of dialogue, there were also meanings to be found. The varying approach to textual analysis is shown in Appendix 6 where I show how multiple meanings can be generated from sections of text as well as how narratives can be viewed as a whole. This was to generate the fullest interpretation possible.

Appendix 7 shows screen shots to demonstrate the process of coding and subsequent analysis. Screen shot 1 shows how the data was coded and annotated; the annotations were initially any thoughts that were stimulated through reading the transcribed text, such as recognition of conflict or contradiction in the narrative, or ideas on why the participant might have said what they did. Many issues emerged in coding that did not relate to professional identifications, such as the experience of the course, and these did not form part of the analysis. Screen shot 2 shows the site of node management. This was necessary because, having broken down the text, I was faced with more than 160 nodes to generate into meaningful theory relating to

identifications. In this screen showing the coding, nodes were expanded or merged. Through visiting and re visiting the nodes, reorganising and re labelling them to represent new, broader content ideas, focussed themes began to appear. I prioritised and selected, using the most densely coded notes to determine the issues on which to concentrate, as well as the issues that made most sense to me. It was here, in the creation of codes and in their aggregation and selection that the framework of identifications was brought to bear. This allowed for ideas to flex, and permitted the analytical focus to move around relevant areas, without losing ideas. It was deductive, but to describe it as entirely deductive would be misleading, as it was both open to the narratives as for any inductive qualitative research, as well as sensitive to the framework for interpretation offered by Holland et al. (2001). Hyde (2000) describes qualitative research as necessarily containing a balance between induction and deduction and this is also apparent in my research at this point.

Screen shot 3 reveals how these emergent ideas were integrated alongside the text from which it came using 'see also' linkages. These were useful in expanding and exploring the connectedness of ideas. Gradually I refined the nodes, amalgamating and uniting or discarding until ultimately the analysis was expressed in themes. Screen shot 4 shows how, as ideas became clearer, I wrote more memos, capturing ideas in the context of the progress of the research. This approach of significant data exploration with both line by line analysis of the interview texts and broader interpretations using extended memos and annotations, favours the construction of theoretical analyses (McMullen, 2011). As Wetherell (1998) suggests, cited by McMullen (2011, p. 206), in this way the critical considerations of individual positioning within discourses have a place in the data analysis, by offering a 'molecular approach' to conversational analysis. This is in addition to the wider appreciation of the contexts (a molar view) and acts to mine the data for as much breadth of insight possible. Screen shot 4 shows my ongoing integrated analysis, expressed as memos, and here emergent themes can be recognised. The analysis did not end here, but moved from NVivo into hand drawn diagrams, developed to model the research findings. The diagrams in the analysis are the finished elements of this early modelling.

The interviews were so fascinating, and pattern coding so intricate, that I felt overwhelmed at times by the mass of detail. Stepping back and trying to make coherent sense of what was happening was probably the most difficult part of the research. The recognition of different cultural influences was sometimes complex. Often participants framed their words to me as in 'when I was in India' or 'having studied in the UK' which allowed me to locate their ideas, but sometimes too this thinking occurred at a less conscious level, whereby from my knowledge of practices both in England and in India, I ascribed their ideas to locations as I thought appropriate if it were not clear. Keeping an open mind about these issues formed a part of the reflexivity I strove for within the project and to ensure a balance between the participants' truths and mine (Higgs, Horsfall, & Grace, 2009). I found myself simultaneously drawn to detailed coding and data labelling as a means of making sense of the wealth of information whilst also rejecting this over neat, overbuilt and abstract meaning making. Somehow I established a middle way that allowed for maximisation and diversity of information whilst not forcing the creation of a false hierarchy.

The analysis did not end there, during the process of writing up I continued the analytical refinement of the data. Having acknowledged that analysis is a process, rather than an act, I allowed the meanings to come to light slowly noting that visiting and revisiting the data are not acts for the transcription alone, but also the analysis in all its forms (Boeije, 2009). I was not alone in terms of my interpretations as my supervisory team were extremely helpful in shaping the way in which I saw the results and discussions with these were added to my research diary. I reviewed this diary at regular intervals to add to either annotations or memos.

4.8 The Use of Technology in Interpreting Data

The analytical process occurred through the many different ways in which I drew meaning from the narrative data and here I explain my ongoing analysis and interpretation of data using NVivo software. So far I have outlined the mechanism for capturing and storing the data, and have begun to outline how I captured the glimpses of the lives participants had offered. This involves a

consideration of the appropriateness of content, the coding approach taken, in addition to a critical review of my engagement and what I have taken into the analysis. From the pilot study I understood that analysis and interpretation of information gained are integrated and ongoing throughout the project rather than being solely located as a single stage in the research process. Thus interpretation has formed part of the interviews, the transcription, analysis and writing up phases.

Having recognised the importance of my place within the research and an existent theoretical framework, the integrated nature of analytical processes (see section 3.3.1), a mechanistic approach seemed to be an antithesis. However, the challenge to code and analyse twelve detailed and very different interviews was immense and, recognising the complexity of the task, I sought assistance with data analysis through the NVivo computerised programme (Richards, 1999). It offers a storage and organisation function for qualitative data that facilitates the revelation of ideas and enhances the viewing of words and thoughts, by supporting the establishment of connections and flows of ideas (Bazeley & Jackson, 2013). Most importantly it aids collection, recall and reflection of and on ideas; I found it invaluable in maintaining 'contact' with disparate and complex data. It uses traditional concepts in qualitative data analysis, the generating of codes and the consolidating of these to form nodes and provides a supporting framework to contain and present these as the research continues. It also offers more quantitative approaches to analysis, for example tables and measures of word frequency, but I quickly abandoned them as single words had little to offer my search for ideas.

Richards and Richards (1994) express concern about the distorting impact of technology in qualitative research, implying that it interrupts the seeing of rich description. However I consider that the software was supportive in this, since I fractured the text in multiple ways and clear and differentiated storage of these ideas was a useful form of generating clarity. As ideas generated by annotations and notes from a number of interviews began to coalesce, I wrote memos or made see also links relating to them. These forms of recording ideas between transcripts and as part of my analysis continued cyclically: annotations

were succeeded with coding notes and these were followed by memos and 'see also' links, then further annotations and coding ideas were made. Ultimately, however, I left NVivo and, for the final workings of interpretation that formed part of writing up, drawing images to help me see, and therefore define better, what I was doing (Corbin & Strauss, 2014).

I have viewed the two dialogues with each participant as one extended discussion with the time lapse between them permitting some space for the development of ideas and reflection for both the participants and me. However, for some participants, the fact that the interviews took place on either side of the boundary marked by the end of the programme may have been significant to the interview content and may have been reflected in the narrative. Therefore I note 1 or 2 after the participant's name in quoted text in the analysis to distinguish whether it was the first or the second interview.

Analysing and interpreting the data as described above allowed me to integrate my thinking about the interviews and the context within which they were shaped to create as full as possible an appreciation of the intersubjective space that was manifest between us. Exploration was undertaken with all the material available: diary entries, reflexive thinking, interview transcriptions, annotations, nodes, 'see also' links and memos (Charmaz, 2014a). It is worth noting that this is her method of approach, but not her means, as Charmaz herself does not use computing software to analyse (Charmaz, 2014b).

Having explained my approach, I now return to reconsider my position as researcher in data analysis and interpretation.

4.8.1 Researcher Role and Professional Identifications

I have already suggested that data collection would be boundaried with regard to its relevance to professional working. However decisions around relevance are not always straightforward and there was a tension around identifying relevant data and incorporating a diversity of life settings, since clinical practice

contains a number of overlapping psycho-socio-cultural contexts that have a bearing on professional identifications (Edwards & Usher, 2008). For example the personal disclosures that formed part of the data set, offered by happenchance rather than request, were addressed only where they bore relation to professional working. In order to manage this I maintained a continual, critical awareness about the relevance of data working to include only the relevant aspects.

Initially I expressed my desire to understand cultural shift as a neutral, or professional, teaching issue. However this is personally framed by my experiences of transition to physiotherapy training and working in Brazil, both of which caused me sensations of intense dislocation. The Indian students' apparent labour with professional identification adjustments resonates strongly with me and in the past I saw MSc students perhaps through my own experiences. Preconceived views would have prevented me from engaging with the true nature of their experiences during education and all that this entails. The research demands an even handed approach when it comes to critical understanding and this is applied to the researcher and the participants. Witnessing and reflecting on the base motivations of us all has helped me see the courage and fortitude of the people involved in a more real way.

According to Kuhn (Steinmetz, 2004) in his incommensurability theory, not only is there is no neutral position from which to consider the social world, but neither is there a static location from which to view it. This is clearly seen from earlier discussions regarding my role(s) and identifications (see section 1.4 and 3.3.1). To counter this paradox, rather than objectify participants (with the attendant implications of imperialism and colonialism), or to fix myself to an identification that is undermined by the tensions within it, I have tried to identify with the area between my world and the participants' worlds. Thus using my considerations *and* the participants' narratives I have been able to enter a new subjectivity. Equally I have viewed what participants have said about the programme to critique its approach to cross national education.

4.9 Chapter Conclusion

In this chapter I have explained the impact that the methodological considerations outlined in Chapter Three has had on the method, the ethical processes and the analysis of the research. Coding and the fragmentation of the data in using a grounded theory type approach was a necessary starting point of the research method, but so was the more complete narrative analysis. I incorporated a mixture of deductive and inductive approaches to establish the interpretive stance towards the findings and the meaning of the narratives offered. The NVivo software helped to collect and contain the various interpretations and establish links between ideas in the data. I have outlined some of the practical issues in the research process and I have exposed my role as a reflexive researcher, where the exploration of the participants' experiences is recognised as a social process and thereby my relations to them form a key consideration. Through this I have been forced to recognise the complexity of the engagement between me and the participants.

From this analytical perspective individual and social meanings have emerged and, in the analysis chapters that follow, I address professional identifications and the context of the course programme, how it influences students and what we might learn about course delivery from the student experience.

5 Chapter 5. Participant Identifications in the Structural Worlds of Physiotherapy Practice

In this chapter I address the first research aim of exploring participant identifications. I deductively generate these through the framework identified in Chapter Two, Holland et al.'s (2001) perspectives on identifications and agency. I explore in detail the underpinning influences that determine treatments and the physiotherapy response to this in terms of practice and approach. The meanings of the terms 'active' and 'passive' are explored in relation to the power dynamics of practice and treatment conceptualisation. Confidence is seen as important in physiotherapy working and forms an example of the negotiated formation of identification. Agency is also established in relation to physiotherapists' avoidance of medical interference. I incorporate these theories into an 'engagement' model of physiotherapy practice. This transcends national differences, and functions along a flexible continuum of mutual influence between the therapist and the patient.

5.1 Introduction

In the following two I explore the meaning of the professional identifications of the participants. As I do this it should be remembered that these have been shaped by education at one specific educational establishment in England and practice (in the main) as experienced in India. The lack of work experience for most of the participants means that the identifications presented are those presented by the course and then envisaged as forms of practice.

Holland et al. (2001) suggest that identifications are formed from the interrelationships between individual discourses and through these the structural and symbolic influences connecting physiotherapists, patients and others in their working context are revealed. Through the participants' narratives the issues of both contextual structure and their agency become visible. Dall'Alba and Barnacle (2007) suggest that the new ontology of learning needs to foreground questions of 'who people become' not just what they learn and

exploring the participants' identifications of professional work practices gives insight into these changes in being. In Chapter Two (see section 2.5) I outlined how professional identifications can be seen as located in these different perspectives, through individual as well as shared viewpoints, and in this way perceive something of the cultural worlds within which they were formed. I gathered working identifications by allowing participants to describe various treatment values, practice norms, systems of knowledge and understanding; who they felt they were as well as who they considered others, mainly patients and doctors, to be (Holland et al., 2001).

From an amalgam of their individual views, I was able to bring together collective perspectives. I allowed consistency in areas of participants' discussions to generate descriptions and, through these, see glimpses of the social, political and complex cultural worlds of therapy practice - influenced by and through structural and historical circumstances. I have used a framework of identifications offered by Holland et al. (2001) to shape my thinking of physiotherapy practice and this results in a deductive analytical approach. Through the participants involvement with new and different professional constructs found on the course they were able to create and discuss an altered sense of individual working identity (Grimshaw & Sears, 2008). Through their identifications, the power aspects of their cultured worlds became visible and the participants' narratives reveal their own influences and authorities. Cultural capital is gained in certain contexts by the practices offered and these practices are seen as highly symbolic.

I saw the participants' narratives as revolving around three interlinked areas of discussion: firstly the variations in practice between India and England, secondly the communicative acts necessary to sustain working practices and lastly the different kinds of relationships sustained (or not) with other members of the medical team. As I explore the findings, I expose the meanings of these identifications with practice and I draw on sociological theory, particularly from Holland et al. (2001), Bourdieu (1986a, 1990; Goodman, 2009) and Geertz (1973) to explain the structural issues relating to power relations, symbolic practices that sustain professional cultural capital and participants' potential

agency within the context of the physiotherapy practice they describe. In doing so I generate a 'mutual engagement' theory of practice that incorporates patients and physiotherapists.

Firstly in section 5.2 I address how the participants described a change in preferred treatment techniques, and how they now adopt models of practice favoured in England. This manifested itself in their rejection of electrotherapy as a technical treatment application and their increased utilization of manual therapy[15] (see section 2.5.3). These changes in treatment methods were underpinned by a new treatment focus on functional ability rather than pain relief. In my interpretation I argue that both electrotherapeutic and manual approaches retain professional power with the physiotherapist.

I also expose tensions in participant narratives around the adoption of different treatment approaches, the varying expression of using these as cultural capital and the management of fluid power differentials between therapists and patients that result. The participants consistently defined their changes in practice as a moving from 'passive' to 'active' forms of treatment (section 5.3). As I explore these notions, it becomes evident that these terms, which purport to relate to patient activity, are limited in their explanatory capacity of therapeutic encounters. They do however help to focus attention on the structural nature of professional power relationships with patients, and these are exposed as being complex, multi-dimensional and flexible. They are disrupted by health care relationships which are suffused with symbolic meanings, economic implications and sometimes conflicting patient and physiotherapist understandings of treatment. How treatment actions are determined is entangled in these issues within therapeutic relationships in different locations and I explore how the participants work in relation to the different power dynamics generated.

[15] Participants used a number of terms in relation to these techniques, I will continue with manual therapy for clarity. See the glossary of terms for the alternative nomenclature found in quoted text.

The focus then changes in section 5.4 to a more individual perspective as it explores a dominant discourse around the importance of self-presentation and self-expression – particularly around confidence and its relation to patient engagement with treatment. The transition in treatment focus from pain to movement is rooted in teleological issues within the wider context of practice, but for participants it also generates a greater awareness of communication within practice and a greater presence in the therapeutic interaction. In section 5.5, after considering approaches to practice located in greater degrees of independence in working, the chapter closes with a review of participants' envisaged agency. The participants express ways in which they could try to sustain their new identifications which are supposed to allow greater decision making capacity, and integrate these into an Indian practice location. Here participants grapple to integrate practices from one context into another, and these attempts to harmonise learning and practice focus around increasing perceived agency. This is achieved by avoidance of medical influences on practice through a variety of mechanisms and through independence of their own development.

Finally in section 5.6 I explore the broader meanings of practice to both India and England and generate a new model of physiotherapy practice one that encompasses the activity of both the patient and the therapist. This model incorporates an awareness of local and structural influences on working contexts and focusses on the social and relational nature of physiotherapy practice, something little recognised in past research.

5.2 Adopting New Treatment Ideas

The participants reported the wide use of electrotherapy as part of treatment in India, a prevalence also noted by Fidvi and May (2010), but recognised that manual techniques dominated treatment approaches in England. This is understandable since the teaching of manual techniques formed a significant part of the musculoskeletal programme route. Conversely, electrotherapy does not feature at all, reflecting the decline of its use in the UK over the last 30

years. So the absence of electrotherapeutic modalities within the course is a key, observable difference in physiotherapy approach in the two countries:

> *'..I was expected to do er electrotherapy quite a lot* [in India]..' SB 2

> '..in *India mostly practice is ... based on electrotherapy... I mean er here during my studies er we are more like into manual therapy using technique like McKenzie, Maitland so that is a change I feel has been after I have done this course..*' Nick 2

Participants also consistently attributed positive feelings to the new treatment approach of manual therapy and saw it as highly skilled:

> *'..I have used it* [electrotherapy] *er for a while now but er, I don't think so it's as effective as manual therapy like .... which er I have learned more about when I came here the um, all the other manual therapy techniques I feel those are more effective than electrotherapy..'* Nick 1

> *'..I think er, manual skills are very important, but they develop over time, I think the skill develops over time, and the precision and the accuracy develops over time and er with practice, so, good clinical exposure er, might be necessary to develop good skills, to develop different skill and to know which one might be ar, most effective in different circumstances..'* Sue 1

On the contrary, negative opinions were expressed towards electrotherapy. Here SB uses the notion of 'addiction' to express her outlook towards electrotherapy:

> *'..I was like, let's just stay away from all the, all the, you know, e-electrical devices and um, just, just use our hands. So um, I think that that is when I realised that this [electrotherapy] is definitely placebo, because it was some sort of an, addiction..'* SB 2

Since learning physiotherapy is arguably synonymous with acquiring the culture of physiotherapy (Aikenhead & Jegede, 1999) the change in practice described above represents a change in their construction of professional cultural practice. At the start of the course participants would have been in one cultural world,

immersed in its practices and facing another (Simpson et al., 2009). By the end of the course they have clearly located themselves within the English practice cultured world of using manual therapy techniques. Overall the cultural world of physiotherapy practice interpreted from the participant narratives is one of all-round English dominance and it is clear that in large part course teaching forms a hegemonic discourse for participants. They adopt English identifications, an acquiescence that extends beyond practice into their choice of clothing for the interviews and names they selected, most of them choosing English names. One of the students adopted the name of a tutor, a highly respected, manual therapist. Sadly this tutor died suddenly around the time of the first interviews, when the participants were choosing names, and it was only later that I realised that this name may have been chosen (consciously or unconsciously) in his memory. Only one participant chose an Indian name, this might have been a conscious resistance to the English cultural overwhelm, or it may have represented a demonstration of his continuing Indian identification. I recognise that participants were likely to express ideas to me as a course tutor that reflect acceptance of the programme content. However, the uniformity and consistency of participants' acquiescence to manual therapy tends to support the idea that new therapy practice identifications were formed from undertaking the course.

5.2.1 Tensions Between Discourses in Physiotherapy

Some of the tensions within physiotherapy practice noted in Chapter Two (see section 2.4) between the evidence based discourse of exercise and the enhancement of professional status through applied treatments were evident in the participants' narratives. This was seen mainly in relation to the value of manual therapy versus the value of exercise, and both were considered important:

> *'..physiotherapy's exercise..'* Kunjan 2

Attempts at balancing the techniques were evident. For example, compare the quote from Nick (p. 116) to this below, where he first prefers manual therapy to electrotherapy, but exercise has prime position, acting to limit 'hands on' intervention:

'..after I've done this course I feel I'll er try to er do er less of hands on then I'll er motivate the patient to do more of the work himself and I'll empha.., I'll explain to him that er I'll do it, [undertake exercise] it is good..' Nick 1

And favouring of exercise was seen as a rationale for no longer appreciating electrotherapy:

'..actually I'm not too keen on giving modalities[16] *because it's, it's not a permanent solution to a any problem, I think exercise is a permanent solution so and maintaining, you can give modalities to get it back to a little bit of normal and then exercise can make it more better, but um, er I don't think modalities work a lot..'* Sam 1

Frequently participants accepted as 'good practice' the move away from electrotherapeutic modalities to both manual *and* exercise therapy:

'..the use of modalities as well is, er, I'm gonna, I'm gonna focus more on exercises and er, mobilisation techniques as compared to modalities..' Kevin 1

5.2.2 Differences in Underpinning Treatment Rationales

In India, pain - the most uncomfortable and personally distressing aspect of illness – is the key focus of treatment:

'..when our patients come to us they are not concerned about anything else other than pain'. Nick 1

'..when I was working in India, ..the idea of the patients was that 'I am in pain, take away my pain, if my pain's gone - then you're effective'. When I did my placement in the UK it was more sort of, 'OK fine, I have this pain, but how can I carry on working despite this pain?' ...and that was the difference that I saw..' Sue 2

[16] Modalities refers to electrotherapy, see the glossary of terms.

The participants' newfound identification with the application of manual techniques appeared to be based in new understandings of the rationale of treatment towards addressing movement and function rather than only pain:

> '[Since undertaking the MSc course*] my primary aim would be to get the person moving, to improve from what they already have, to make it, to make their life better..'* Sue 1

> *'..physiotherapy's to me is, we can say that, it's um, like new skills and new you are learning something in the physical motion..'* Kunjan 1

This harmonisation between the concepts and the techniques of treatment further indicate the coherency of the construct for participants as they form a new understanding that therapy practice actions align with the meanings ascribed to them. They have identified a new rationale for treatment: to improve movement and function and thereby increase patient independence and enable the return to work:

> *'To me it was like we give uh good quality of life. Then we give like .... patient can do that independently in that activity, so is not dependent on their family..'* Kunjan 1

> *'..I used to think, about er, like, what could I do, to er,.. to rehabilitate that injury, but now I think a lot more of how can I g, er, get the patient back to his normal work routine..'* Kevin 1

Professional identifications, like all identifications are dynamic, and evolving (Giddens, 2013) and the identifications outlined by participants reflect those that are dominant in England. As pain reduction is no longer their prime purpose in therapy, participants initially seem happy to reject electrotherapy techniques. However, this new rationale is, in itself, steeped in structural and teleological influences from the English healthcare system, which I now explore.

5.2.3 Teleologic Influences on Physiotherapy Practice

The dominance of manual techniques in musculoskeletal therapy in England is synonymous with the dominance of the treatment rationale focussed on

movement. In reflecting the tenets of the course, participants also reflect those of NHS dominated practice in England and expose the strong economic impetus that explains practice (see section 2.5.2). Government demands on health care for a changing population demographic have influenced alterations in physiotherapeutic concepts for undertaking treatments: the restoration of a patient's independent and economic function to sustain a workforce and economy. It is this dynamic that has permitted manual therapy to flourish in England. The turn towards patient function as a key area of therapeutic engagement requires much greater focus on movement. The treatment of movement can be performed either by the patients themselves (with active exercises) as well as on the patient by the physiotherapist in the form of manual techniques.

A key treatment concept for movement disorders is the increase of joint mobility and, since it is designed to facilitate joint range, manual therapy can be seen as forming a perfect accompaniment to the exercise based approach. This development in practice constructs has occurred synergistically with the move away from pain to movement focussed treatment (see section 2.5.3). This creates a tension between practice and the requirements of practice and there may be two reasons for this. Firstly, manual therapy techniques were developed just around the time when first contact care practice was permitted in the UK (in the 1970s), when claims to professional knowledge were required (and prior to the emergence of strong evidence for exercise based approaches). Secondly, this professional shift and modification to practice can be seen as a way to reflect the professional desire to sustain cultural capital by holding on to physiotherapy specific skills to maintain or gain professional status (see section 2.5.2). As electrotherapy, a form of physiotherapist applied technique with limited scientific justification has waned in its usage, so another, largely empirically unsubstantiated area of practice in the form of manual therapy has emerged to take its place. This development in practice then forms a good example of the interplay of continuity and change within cultures, and physiotherapy has shown itself to have some long term, inherited features such as exercise prescription, whilst also creating others, like manual therapy.

This change in practice creates tensions for the participants as they envisage the transition back to practice in India as those same influences have yet to occur there. A weak economy and other contextual influences outlined in Chapter Two (see section 2.5.1) have resulted in low health care spending. Given the supremacy of private health care and the dominance of the medical profession in the health system, it is unsurprising that physiotherapy practice has remained relatively static and still retains its focus on technical applications, such as electrotherapy. Pain is recognised by the Indian Association of Physiotherapy (IAP, 2014) as central to the purpose of practice and this issue of pain is also culturally/contextually bound. I return to this issue in the discussion relating to patient expectations (in section 5.3.2), but in terms of cultural capital it can be seen that electrotherapy and manual techniques form an embodied manifestation of professional knowledge constructs and in this way manual therapy forms another construction of professionally held knowledge and power, acting to maintain the locus of symbolic, cultural capital with the physiotherapist (see section 2.5.3).

5.2.4 Environmental and Social Influences on Physiotherapy Practice

Having learnt and adapted to new identifications in physiotherapy practice, participants anticipate conflict when returning to India as they juggle meeting patient's demands for hands on (and time consuming) treatments with wishing to apply their newfound knowledge of evidence base practice and exercise prescription. Sue picks up on this potential conflict:

> *'..in that culture* [Indian] *the patients are er, more used to a more passive kind of treatment, rather than taking control over their treatment, and being involved in self-management and taking autonomy for their own er, rehabilitation...patients may not know what to do with it, they'll be like,.. you're the physiotherapist, you tell me what to do, so in that sense I think there might be a clash of mind sets, there might be a clash of er, ..what's best for you..'* Sue 1

Despite the widespread professional acceptance of electrotherapy in India, here Nick distances himself from the practice by suggesting that it is patients who request it:

'..it's a mind-set in India that electro.., electrotherapy works ... it's like er, a mind-set there that people more are focussed and the patient also they have bought into like er from er beginning they have been given electrotherapy and they feel that it is u.., useful..' Nick 1

The number of patients that a therapist is required to treat also poses a difficulty, as described by Sam:

'Indian physio is... when I used to work I used to attend around fifty patients[17] a day, so er to apply evidence based practice and to apply an outcome measure[18], assessment outcome measure would be very difficult there, because you don't really have time to just give the treatment and I would be attending three patients at a time so it's gonna be difficult to apply it there as well..' Sam 2

For a pain related construction of practice, where treatments are limited and defined for the practitioner then this number of treatments is not a problem. However Sam recognises the time demands of English practice. Movement related and more constructed treatments are time consuming, with their requirement for clinical reasoning and holistically applied treatment approaches. Sam is suggesting that it will simply not be possible to practice in an English manner and this forms a good example of the non-transferability of education gained in a different context previously noted elsewhere (Nilsson, 2008).

Participants used the terms 'passive' and 'active' to describe themselves and their treatment approaches and it is to a deconstruction of these terms that I now turn.

5.3 'Active' and 'Passive' as Treatment Constructs

As participants explored their new constructs and identifications, they consistently and frequently referred to 'active' and 'passive' treatments. The frequency with which they used the terms suggests the strength of their

[17] In a UK outpatient clinic a physiotherapist would see approximately 12 – 15 patients per day.

[18] This is a measure of impact; an issue of importance for a scientifically based profession.

identification with them. They described the approach to treatments using manual therapy and exercise as 'active' therapy, as opposed to the 'passive' Indian practice of applying electrotherapy modalities. Thus participants classified the change in their treatment approaches as a move from 'passive' to 'active' techniques:

> *'..in that culture [India] the patients are er, more used to a more passive kind of treatment, rather than taking control over their treatment..' Sue 1*

> *'..I'm a lot more prone to sort of active treatment, and passive treatment like modalities now, I don't rate the modalities er, so much as compared to the exercises..'* Kevin 1

These terms 'active' and 'passive' are colloquial and are not prevalent in professional literature[19] nor the MSc course definitive document. Instead I recognise these terms as those present in the informal discourse of the course, forming part of the lexicon delivered during the programme. The use of these terms represents a form of professional 'short-hand' where the term 'passive' encapsulates an approach to patients that involves technical applications (specialist physiotherapy skills, including electrotherapy) performed on patients whilst an 'active' approach sees physiotherapy as something in which patients participate, frequently presented by the participants as the patient undertaking some form of exercise (both occurring within or, as directed, outside of the therapeutic encounter). They function as a 'common sense' means by which the teaching team understand physiotherapy as it is practiced in different locations.

By considering treatments as passive and active, the symbolic nature of the exchange in relation to what the physiotherapist does to and for a patient and what the patient does for the physiotherapist is exposed. So it this conceptualisation of practice that I consider next before continuing to explore the contradictions exposed in the participant narratives regarding the uses made of these terms.

[19] One of a few articles that refer to this as being part of a physiotherapy treatment paradigm is Levoska and Keinänen-Kiukaanniemi (1993).

5.3.1 Symbolic Forms of Power

The importance of symbolic forms of power in practice has been largely overlooked in contemporary health care considerations (Ferlander, 2007). Öhman, Hägg, and Dahlgren (1999) in one of the few papers on this topic related to physiotherapy suggested that the innate characteristics of the physiotherapist (e.g. gender) characterise the symbolism of physiotherapy. However De Silva et al. (2005) indicate that actions also form an aspect of symbolism in specific contexts, and so cultural capital could be seen to be held by therapists through the treatments they offer. This is very much an anthropological view of practice, but considering treatments in this way, the underpinning rationale of therapy in different locations gives treatment different meanings. Therefore the symbolism associated with treatments are different. For example, in England, the meaning of treatments has been outlined as being movement (and thereby function) related, so physiotherapy mobilisation treatments are highly symbolic. The micro-movements of manipulative therapy are then representative of the larger movements that the therapist hopes (and expects) the patient to perform as exercise. The different aims of physiotherapy treatment in India result in alternative symbolic acts in, for example, electrotherapy as something 'taken' for pain. So in this way treatments can be seen to be highly emblematic of their aims and these are socially defined, varying between different cultural worlds. In order to sustain the symbolic nature of practices, treatments have changed as meanings of treatment have altered and it is this change that is reflected in the changes identified by participants:

> '*..moving away from the electrical modalities and now being able to treat with your own hands and your own skill..*' Sue 1

Geertz (1980, p. 14) writing about symbolism within the traditions of the Balinese noted that the explicit connections between customs and their meaning are often lost, so for example, political tensions were explained through mythology, where fables provided a unifying narrative and theatre explained current context. The situation within physiotherapy can be viewed similarly, where the symbolic meanings contained within treatment actions are not consciously perceived. This level of awareness is an important point to note as therapy does not represent determined acts of dominance by practitioners,

but nonetheless, exertion of cultural capital contained within accepted skills, form expressions of the kind of power relations that suffuse all human interactions. This consideration of physiotherapy constructs, and the authority associated with their use, challenges the professional physiotherapy constructs around caring and patient centeredness (Verma, Paterson, & Medves, 2006).

Physiotherapists retain cultural capital by delivering treatment techniques onto patients. Through the prescription of exercises cultural capital is more shared between the patient and the therapist. The patient's participation in treatment, either by passively having something done to them, or actively participating in treatment, represents their activity or passivity. Viewed in this way the prescription of exercises challenges the nature of the therapeutic relationship, through demanding action from the patient (Bodenheimer, Lorig, Holman, & Grumbach, 2002), and this treatment approach necessarily sets the scene for a more level power relationship within therapeutic interactions, given the loss of cultural capital this represents. These ideas act to explain the 'agency' of physiotherapy practice (Holland et al., 2001) which is in part located by and through the treatments therapists choose to apply and the activity they promote. This becomes how physiotherapists express agency, through how and when their professional power is secured, relinquished or utilised in the therapeutic interaction. It is to a deeper exploration of these terms that I now turn, as an exploration of power relations in therapy and as a form of cultural expression.

5.3.2 Contradictions in Physiotherapy Treatment Identifications

Difficulties arise in describing English physiotherapy practices as 'active', since it has already been established that English musculoskeletal practice includes highly prized manual therapy. This is applied by therapists to relaxed patients, and could therefore be considered a passive form of treatment. Equally the 'passive' approach that students articulated as being present in India contradicts the context explored already in Chapter Two, where relatively lax regulation creates a situation of considerable decision making power by physiotherapists (see section 2.5.1). Participant narratives demonstrate conflicting understanding from course learning as they express negative

attitudes towards 'passive' approaches, whilst simultaneously enthusiastically endorsing manual therapy:

> *'..if you actually implement the manual therapy also in 4 or 5 sessions so that's a good, good practice and you actually get implement in the patients so that's a good thing to do..' Kunjan 2*

> *'I have used it* (electrotherapy) *er for a while now but er, I don't think so it's as effective as manual therapy..*' Nick 1

So whilst English practice appears to eschew 'passive' treatments, it has a professional construct that contains distinctly passive characteristics and these are highly valued professionally. Indeed, treatments in England frequently incorporate a mixture of patient active and patient passive aspects. Similarly, reflecting an English cultural worlds of practice, participants advocated active exercise approaches, while maintaining strong professional identification with valued passive approaches to treatment, undertaking them together in a single treatment session. Here Sam describes treating a patient in England with both active and passive elements:

> *'H[20]: ..and your treatments were exercise based ...? S: Yeah.*
>
> *H: Postural advice? S: Yeah.*
>
> *H: Anything else? S: Er, no it was more about er, postural advice and exercises that er I used to give and er I er did er try manual on some patients so.*
>
> *H: Oh, what kind of things? S: Ah, I gave a P-A glide[21]..'* Sam 2

Sam outlines her experiences on a clinical placement, undertaken as part of the course, and she clearly thinks of manual techniques and active exercise as complimentary elements in a treatment session:

> *'..I saw it was er, like a very good approach towards er, treatment .. was more hands on like and it was giving the autonomy to the patients to do*

[20] 'H' refers to the author/researcher
[21] A posterior-anterior (P-A) glide is a form of joint mobilisation, used particularly on the spine.

the exercises, it was not more about us doing more of it, but making them realise that they have to do it so it was good..' Sam 2

And just as English treatments use a combination of approaches, so do those in India, as treatments are not, after all, solely electrotherapeutic:

'..where I used to work ultrasound [an electrotherapy technique] *used to be given. And then somebody I've given them some exercise they are doing that so, I mean you have to handle a lot of people at the same time..'* Sam 1

Some participants recognised tensions in the active/passive discourse. Here SB ponders the difficulties of choosing between techniques and reveals concerns about the 'passivity' of 'hands on' (manual therapy) treatments as they undermine the focus of treatment on exercises and the active engagement of the patient:

'..if the patient is, is saying it feels good it's because of my touch, it's because of, of, of being hands on, so, in a way er, I didn't want to encourage, that er, that, that, that passiveness in treatment..' SB1

So whilst the terms 'active' and 'passive' are used by the participants to describe national differences in approaches to treatment they are actually not a particularly useful means of understanding physiotherapy practice since, in either country, treatments are not solely active or passive. Additionally these terms are inadequate to describe treatment constructs since they fail to acknowledge the power relations at the heart of therapist-patient interactions and it becomes pertinent to consider this now.

5.3.3 Power Discourses between Patients and Physiotherapists

Just as physiotherapy interventions can be viewed through the lens of structural and symbolic power discourses, so can the involvement of patients. In a commodified transaction of the kind occurring in private as opposed to state provision, financial (the original capital) power emerges. Participants noted the capacity of patients to direct treatments through their purchase of therapy services. The paying patient then holds considerable power over treatment

decision making and the paradox of the active/passive nomenclature is exposed in that patients can be anything but passive in terms of resisting the imposition of an 'active' treatment approach (Contandriopoulos, 2004).

The participants felt that the patients they had seen in India generally wanted the symbolic treatment acts of therapy performed on them:

> *'..we have to use [electrotherapy] because in India they think the if she just give the exercise they think the like they just do like up and down of my arm or leg [describing mobilisations] and nothing, they just took money from us, so we have to give electrotherapy ... so they feel better from that..'* Kunjan 1

The imperative in Kunjan's quote illustrates the lack of control participants feel they have over the treatments performed, given the strength of the patient's position. Others concur:

> *'Well, in India I find the system sometimes to be rigid in the sense that it's not just from the therapist point of view or just from what the doctors refer, but also sometimes from the patient point of view, that if they think that they want something passive, they want something passive, that active involvement um,.. may not come that easily, so it's a rigid mind-set which is sometimes hard to crack..'* Sue 2

> *'I think it's the cultural difference which is er, very, very evident, because er, the mind set back home, er the, the general mind-set is that well I have the money, I'll pay you, you just give me what you could have and, and I'll take it..'* SB 2

The participants interpreted this position as patients failing to understand physiotherapy, and therefore wanting the 'wrong' treatments:

> *'..they don't know that it's [electrotherapy] not curing the cause, it's a temporary treatment. So when patients, just they come and they tell 'I don't want exercise, I want this [electrotherapy], this gives me relief, exercise doesn't', so you have to give them that then..'* Sam 2

5.3.4 Therapist Responses to Lack of Treatment Control

In the face of intractable differences participants presented a discourse that blamed patients, a very similar reaction as I gave my patients in Birmingham. Attributing failure in therapy to patients acts to distance us from, or to redirect the responsibility for, the social unacceptability of our professional constructs or the lack of impact of our treatments. This can perhaps be seen in the prevalence of the constructs of compliance, adherence and concordance of patients with physiotherapy practice in UK literature (Middleton, 2004) which could be interpreted as attributing poor outcomes to patients not doing as they are instructed.

Participants also use the distancing construct of placebo to describe treatment effects, which places less blame on the patient. When they thought about having to apply treatments that they now considered as non-therapeutic (i.e. would not have a rehabilitation or healing effect), there was a notional recognition that they could still have some impact for the patient in the form of psychological benefits:

> *'..giving a placebo effect for them as well, to feel that something is being done to them, and then only they will respond to treatment, otherwise they would be thinking in themselves that they haven't been giving..'*
> Kevin 2

Participants applied the term 'placebo' to any form of treatment demanded by patients and, indeed, began to use this term instead of electrotherapy as the interviews progressed. I interpreted this as a means by which they justified the use of treatments over which they had no control or decision making power. Despite the recognition that paying patients can wield significant power within the therapeutic relationship, this is not necessarily always the lived experience. SB felt that she did have a great deal of authority with patients in the following example, where her power was asserted by making patients wait as a matter of procedure:

> *'..people just tend to accept treatments from the physio as they really, they, they really worship physios, or doctors, and they think they are they*

are Gods. ..I remember this patient which was a case of low back pain, and er the standard protocol as such would be, to er, er ask the patient to wait for about 10 minutes first, then er, use some of the um short wave er machines on the patient and then treat some other patients in the meanwhile, and come back and do some extension exercises..' SB 1

Alternatively power might be seen to be something shared:

'..before it used to be like lot more passive, now I think that if I involve the patient more and more active, that it could help them better that, that will boost their confidence that, that will er, because they are been involved er, in their own (health) *management..'* Kevin 1

The differences in the perception of control seen here by SB and that offered earlier by both her and Sam (see section 5.3.3) reflect the diversity of the therapy environments that participants have experienced. The multiple social and economic factors in India, including their social standings in different practice, are manifest in multiple power discourses within the therapy engagement itself. This facilitates a fluid treatment arena with a wide potential variance in power expression.

5.3.5 Responses to Fluid Treatment Arenas

Differences in therapy meaning constructs for therapists and patients, divergences in the mechanisms of payment and the inherent cultural capital uncertainty that result from the variable locations of symbolic power in the performance of therapeutic relationships - depending on the treatment approach - cause uncertainty for the participants. Whilst their narratives position the patients as 'active' or 'passive' in treatment settings, this terminology may actually also represent their relative 'passivity' in the face of patient demands. The undermining of professional knowledge systems created by unassailable patient demands is managed by participants either through rationalisation processes (such as the acceptance of placebo) or through discussion and negotiation. SB outlines such an approach:

'..so it's not about being, er, having a partnership, it is more about, being, er, dependent I think on each other, er, be, .. it's about giving services and exchanging roles..' SB 1

This is a situation that they feel the course in some ways prepares them for, through the development of explanatory skills:

'..OK, we need to think critically, what's best for the patient, this is what the evidence tells me, this is what might be the best thing for them, I need to involve them into the decision making as well..' Sue 2

'..I'm gonna focus more on exercises and er, mobilisation techniques as compared to modalities and er, and my reasoning is much more better now, I could reason conditions out and I could explain the patient better and explain the patient better after doing the Masters..' Kevin 1

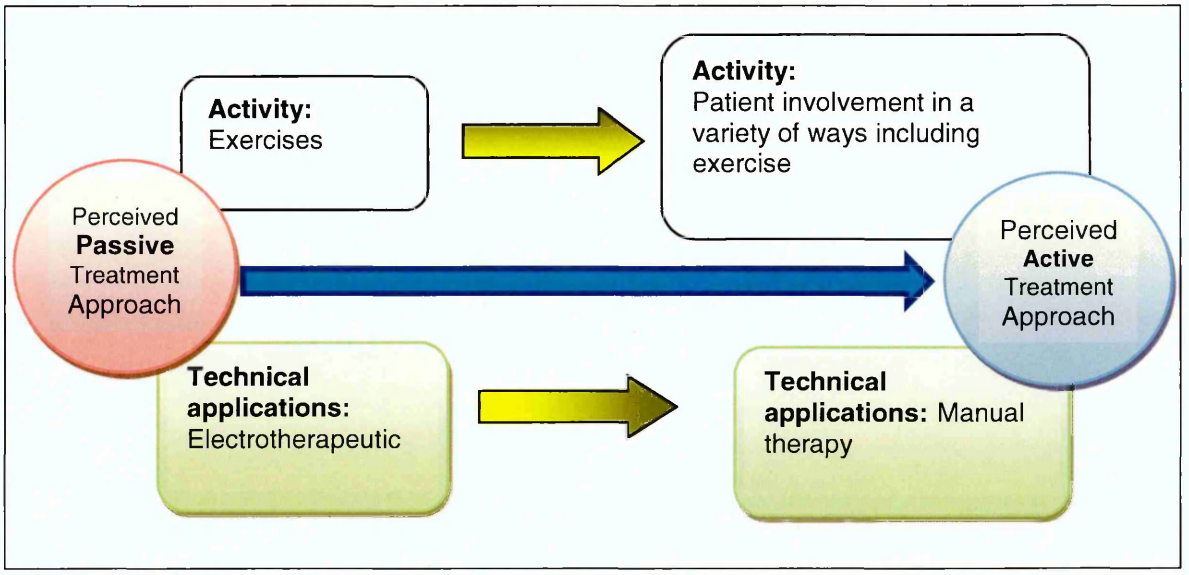
Although differences are still discerned between country contexts, participants sense a greater openness to treatment instruction in England where patients potentially have less capacity to direct therapy:

'I think um, the psychological um, message behind physiotherapy is, is quite different in both these countries, because, in, in one [India] you expect to be touched all the time, ...I think patients [in England] *are more willing to be in charge, and er, they are, they're more willing to learn what, what we can teach, instead of being completely er reliant on what we do on patients..'* SB 1

Their approach then becomes much less about rejecting passive treatments in favour of active ones, and much more about having greater choice of passive techniques, in addition to a recognition of the need to involve patients in treatment decision making – for at least some of the time.

Figure 1 over the page, illustrates this more complex shift in participants' identifications as a result of the course with changes being shown as occurring from left to right:

Figure 1: Practice Development Diagram



This direction is represented as being from the perception of passivity to the perception of activity with regard to patient engagement in India vs. the English context. However both locations are shown as really being a mixture of active and passive techniques, but incorporating different types of techniques. The new focus on movement brings with it the need to discuss and negotiate with patients. Cultural capital, embedded in the symbolic nature of healing practices, can be seen as something that is either retained or shared by physiotherapists, depending on the treatment approach. So physiotherapy treatments are formed from a balance of power influences, through the interpretation of, and response to, the clinical situation by therapists and patients. Practice in therapy is based on what the physiotherapist and the patient do. Modelling the therapeutic arena has, in the past, tended to consider the physiotherapist but, within the therapeutic interaction, patients can, and do, exert structural and symbolic power which also requires consideration. The 'middle ground' of collaborative treatments is perhaps an ideal construct. But in creating a concept of practice that incorporates an engaged and negotiated activity for both the patient and the therapist, the therapeutic relationship is fore-grounded, an aspect addressed further in section 5.4.2.

Both mobilisations and exercise require forms of patient participation: purposeful relaxation in the case of mobilisations and active engagement for

exercises, neither of which are necessarily effort nor pain free. Participants recognised that they required good therapeutic communication to support their new treatment ideas:

> *'..initially when I was in India when I had not done my Masters here, I would think like er, I would try to explain them ...er but if they are not listening and their argument about the treatment they want, er we have to give them, but er when I have studied here now I feel that I'll try to convince the patient more strongly and er advise him that this er the thing in which I'll do for him is more effective than what he thinks is more effective..'* Nick 1

From the discussions in this section, I suggest that physiotherapy practice in England has elements of passive treatment, the same as Indian practice. And so the issue becomes - why do we say they are passive, yet fail to recognise this aspect in our own practice? Answering this question is the basis of Chapter Six.

5.4 Communication across a Power Divide

It becomes obvious from the discussions around activity and passivity, that the therapeutic relationship is one that requires some consideration. Given that physiotherapy practice outlined previously is about engaging in fluid power relationships. Physiotherapists and patients express agency by negotiating activity. Dealing with potentially challenging patient constructs around the requirements for health care recovery, then it is not surprising that confidence and communication form important aspects of the physiotherapist perspective and all participants discussed confidence (or lack of it) during practice.

> *'..that has been a change and er I'd have learned er skills on how to talk to people and how to talk to patients... er in a more professional way and er how to convince them because I, if earlier it was a patient I, I'll ask him better. I, this would be I'll tell him that this is more effective for you and if he says no I'll leave it there and I'll do what he demands me to do, but now I'll convince him with the er I will convince him strong, more strongly than I did before..'* Nick 1

5.4.1 Confidence in Practice

The 'confident therapist' identification presented by participants forms a clear example of both the fluidity and mutuality of identifications and a self and professional preserving response to them. In some ways, coming to England to study on a theoretical course had the initial effect of impeding confidence:

> *'..it was more than a year that I didn't even see a patient, so I was quite scared to even touch the patient..'* Sam 2

The adjustment presented opportunities for the development of confidence and participants identified strongly with confidence enhancing aspects of M level study, not only from the professional learning gained from the course per se, but also from the experience of studying abroad:

> *'..and that was what changed with er, the BSc and MSc... I'm thinking ... I feel a lot more confident now..'* SB 1

> *'..international interaction has developed me, but um talking to different people coming from different backgrounds in the UK ... has transformed my thinking tremendously, so I'm not really af-afraid of interacting now I'm not afraid of sharing my views boldly, but I would have thought at least four times had it been in India, so I have that er, freedom of expression I would call that ... I think so nice to develop and not be ju.., sort of, you know, pushed down with the foot and say that this is what I think is right and even you must, because I've gone through that back home and er, ar, that is where I think that my development was suppressed so, letting that foot off my head and springing up was definitely really helpful in the UK and I've, I've developed, I feel..'* SB 1

> *'in India there is sort of perception that, if you do Masters from abroad...*[it is] *... better as compared to, you know, doing a Masters from India, because you'll be having some sort of diverse knowledge about, the research going around, outside and effective things so, .. that helps in terms of the rapport as well because he's [the patient is] gonna trust you, you have done a Masters from the UK, and you know better as compared to others, ..., it gives you, sort of confidence, that you went to a different country you went to their education structure, you did well,*

over there, .., and now you can apply them in your country, so, that, that helps to, you know, give you sort of confidence..' Kevin 2

Adjusting to a different culture also had an impact and Sue reflects some of these difficulties:

'I think it's a hard nut to crack sometimes to come out of their[22] *shell and then say 'OK, fine, how do I integrate with the people here? They think differently, I think differently, where's, where's the common ground', and I think that is hard, ... but I think it's about being open minded and being discerning, and also at the same time it's an investment, nothing comes without effort..'* Sue 2

Good treatment results can also help further build confidence in patients if this is communicated well to them:

'..you should tell them that this is the condition before, ... and this is what you have achieved, so you should be proud of you for that, ... so you are praising him, so you are giving him the confidence that he is doing well as compared to others..' Kevin 2

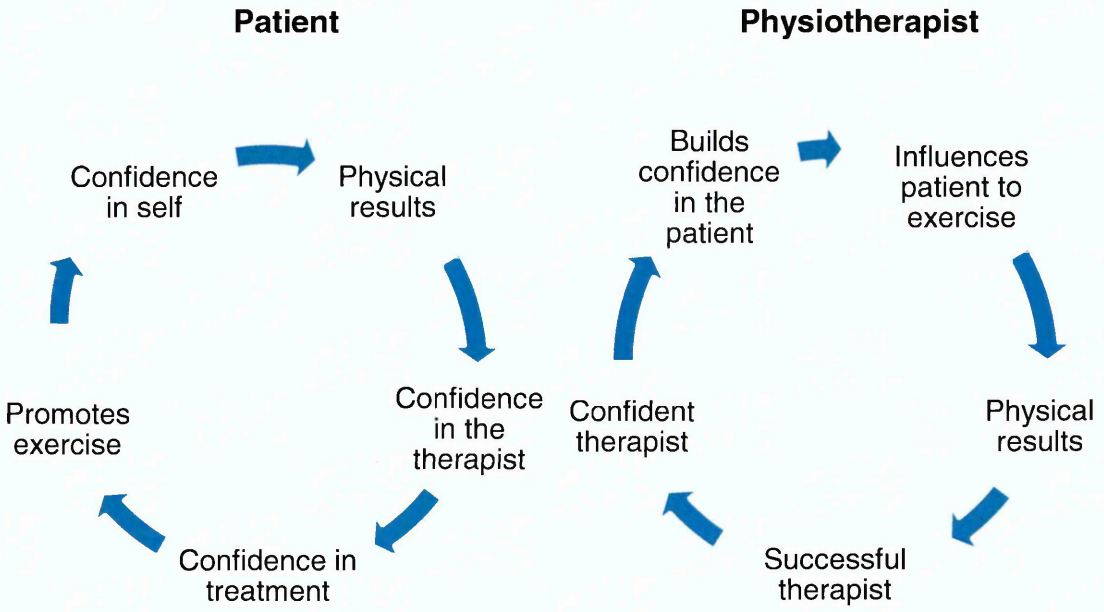
Participants recognise that patients respond positively to the confident physiotherapist. They believe that confidence promotes patient activity and self-belief, which acts as a valuable contributor to positive treatment effects. Patient and therapist enter an interdependent interaction which creates a 'virtuous circle', further enhancing the response of the patient and the confidence of the therapist. The implication is that whilst the specifics of practice in the programme have limited value in India, what matters instead are the authority and the confidence to practice:

'..now I think, er, before it used to be like lot more passive, now I think that if I involve the patient more and more active, that it could help them better that, that will boost their confidence that, that will er, ar that will help to get their belief in you, because they are been involved er, in their, ar their own management..' Kevin 1

[22] Sue may have been distancing her own struggles to integrate here as she appears to talk about the difficulties of others to assimilate, rather than her own.

Figure 2 below, demonstrates diagrammatically the interrelationship of mutual confidence in therapy, as an example of how identifications are socially constructed (Bauman, 1996). Feelings of enhanced cultural capital may come from the perception that a Masters from England is superior to one gained in India, as demonstrated in Kevin's quote above and having a Masters helps increase rapport with, and respect from, both patients and colleagues. This status positively affects both the therapist's confidence in the treatment encounter and the patient's confidence in the therapist and may consequently function as a key source of gain from studying in England.

Figure 2: The Confidence Cycle in Treatment Diagram



This is supported by another quote from Kevin:

> *'H: The word that keeps cropping up is, is confidence, and it's, it's sort of like a cyclical thing, you, you need confidence in yourself, but also your patients need confidence in, in you, (K: yeah) and, and the two things are kind of related?*
>
> *K: Yeah, if you've been respected you, you will be er, like, you will achieve that confidence of the patient so it's a sort of interrelated things, if you've been respected, you have, you have that confidence..'* Kevin 1

5.4.2 Metaphysical Engagement in Physiotherapy

Section 5.3.3 has outlined an approach to working with patients that is more communicative, based on participants' recognition of their need for supportive therapeutic communication. Any model of practice that contains an appreciation of a patient's psychological presence in the therapeutic encounter will result in raised awareness of the need to engage with patients' emotional landscapes. This is exampled by Kevin and SB:

> *'..previously I used to think that pain is a disability, but now I think pain impact the* [cricket] *player, emotionally and er, it impact the player, you know, it's, it's not just few, few things, there are few things I would say, first thing is pain, is just not physically it impacts a bit emotionally as well..'* Kevin 2

> *'..in the UK it is definitely more er, covalent I would say, the whole interaction is different, so everybody feels like a, a, a part of one big team which is focussed round the patient, it differs from, from hospital to hospital, but um on a whole it is more visible here, and um, just the awareness about services..'* SB 2

The use of the word 'covalent' (wonderfully) encompasses the mutuality of therapeutic interaction and performance and the requirement for the dual engagement of therapist and patient. With the new professional constructs formed by the participants the significance of the therapeutic relationship comes into sharper focus. The mutual engagement of practice and psychological approaches to treatment forms a large section of coding of the narratives. Participants outlined persuasion, explanation and encouragement. Here SB identifies a psycho dynamic aspect of treatment:

> *'..I think I've seen though people do say well, I, I would want to take charge of my condition, I would want to be active, but, when it comes to actually promoting activity, er ...it's actually going deeper than what patients want, into their personality and er, their physiological aspects of wants and, and desires from physiotherapy, 'cos, it's was quite a tricky process..'* SB 2

And these issues were probably not a dominant discourse in their previous practice and study:

> *'..I used to consider psychological issues, but they were on my sub-conscious mind, I didn't know that they are, they play a good, they, a huge role, but after coming here, I, I realised that whatever I was doing, it does have an impact on them..'* Kevin 2

Treatment identifications are also emotionally multifaceted and different levels of both patient and physiotherapist engagement during treatment is noted by participants in discussions. A construct of psychological engagement is woven within the physical, which challenges the mind-body dualism prevalent in a medical model of health care (Mehta, 2011). Here Kevin (again talking about treating a cricketer) outlines the psychological-physical-functional cycle:

> *'..now I think er, even if you treat a patient physically it, ... you won't be sure the he is gonna do good, unless and until you, consider the psychological issues because, even if he is physically fit ... emotionally* [if] *he is not confident enough to use that physical strength of his, in the activity which he is doing, then he's always at risk of injury because he would be in, in the sort of protective mechanism, he, he won't give his best, so his performance won't be, ... good enough so, he, and that would ... create a s-sort of circle, if his performance is not well enough, he won't be in the team, and that would impact on him psychologically, and that circle will go on and that would impact, impact the athlete in the longer er in the longer time span..'* Kevin 2

The cyclical model of confidence proposed in Figure 2 (see pg. 139) encapsulates a power balancing approach that characterises optimal treatment situations. But the paradox for practice is that it is not only patients that must engage, physiotherapists too have to demonstrate their ongoing commitment to the therapeutic process by engaging in a deeper way with their patients:

> *'..after coming here I, I can understand the patient better..'* Kevin 1

And this process is ongoing within treatment:

'..a good physio is not somebody who'll give the exercise 'n just leave okay you do it, [it is someone who will] *take a follow-up whether they are doing it or not, measure it whether something has improved, what was there before or not..'* Sam 1

The 'active versus passive' narrative that has featured so highly in this research comes to fore again when considering the cognitive engagement of the patient more carefully. While mobilisations, for example, can be seen as passive treatment techniques, the patient is not necessarily totally passive in receiving them. A physical 'passivity' is required of the patient in order for a mobilisation to be performed but a cognitive acceptance of such a technique is important, since the person must remain still and relaxed, even when the procedure is potentially uncomfortable. Thus passive in this situation takes on an active cooperation to allow the intervention to proceed. Indeed patients can express their agency (activity) through not engaging with exercise or by asking for particular passive treatments. It raises further questions about what is meant by 'passive', as well as to whom it applies.

Given then that treatments have aspects of profound non-physical components, involving both critical thinking and embodied meanings for practice, it is also worthwhile considering the concept of therapist passivity in the treatment concept avoiding a narrow definition of 'passivity' and incorporating cognitive and psycho-emotional elements in addition to treatment. When a physiotherapist offers a 'passive' treatment to address pain, they too are arguably also being 'passive' in just applying a pre prescribed treatment for a single issue and avoiding a wider cognitive or social engagement. Taking a more functional approach necessitates a more holistic and individualistic view of the patient. The consequent more active physiotherapy assessment and a holistic treatment, results in a more active patient. There is a positive relationship between active and passive engagement, rather than the negative one assumed previously. In other words, a 'passive' patient treatment does not equate to a more 'active' physiotherapist and fully and holistically engaged physiotherapy results in active patients when taking a broader, not solely physical, view of practice.

Underpinning such an approach SB identifies the fundamental issue of equality. In order that the patient-physiotherapist relationship can be characterised by negotiation and achieve dual engagement in therapy practice then respect for the person is inherent in the performance of practice:

> *'..I like er how different people view interactions, as, as valuable pieces, so here I mean that er, everybody is, is regarded equal, and one wouldn't really judge somebody based on their background or, or um or,.. socioeconomic status, or the kind of work one does, and even the whole chemistry between a student and a teacher differs and er that is what I really like, that one is free to stand up at that level and, and question, at the same time reason..'* SB 1

An emancipatory element can be detected as desirous for patients, and themselves as both therapists (and potentially) students.

5.5 Agency in Physiotherapy Practice

Having considered the new treatment approaches and what this means with regard to how identifications are constructed for participants I now consider the impact on these of the structural confines of physiotherapy practice. This brings with it a consideration of agency in working contexts. Much of the discussion about career and working locations could be related to financial discussions around payment and there is no denying that these are important considerations. However social roles (daughter, son, wife, and husband) also constrain where and how people work. Due to my focus on professional identifications these were neither apparent to any great degree within my data nor appropriate to share. Kevin recognises the importance of these issues:

> *'..it's not about earning money; it's about earning that respect in a profession, because to me money's not the first priority, earning that respect in a profession, other person appreciate what you have done, what you have contributed to the practice is much more to me, because money, I have, 50 age ahead of me, I'm just 27, 26, 27, so I can earn money at any age, like, I'll be earning money, it's not that if you just-go-*

for-respect you won't be earning money, you, because earning a respect is my first priority and the money will definitely follow..' Kevin 2

The participant narratives have already hinted at the widely varying nature of status and power relationships in work places and some of the mechanisms by which physiotherapists enhance their working independence. In order to now examine the social position of physiotherapists, I consider their relationships with two other social groups in the health care arena, representing inter and intra professional working, that is between other doctors and other therapists. This exposes the participants' mechanisms for managing the hierarchies within practice. While participants did discuss family and individual relationships and although they are important to participants' work constructs, my focus here necessarily remains on professional working relationships.

There are clear differences between England and India in how physiotherapy relates to medical practitioners as well as how physiotherapists associate with each other, and this is particularly pertinent for those returning home from overseas study with enhanced sense of cultural capital and their more confident self-presentation. How the interviewees intend to manage the consequent disjunctures between different locations and cultured worlds of practice emerges in their expressed hopes and desires for their future employment. I explore their perceptions of agency before considering how they envisage their identifications as embodied in new ways of working.

5.5.1 Agency as Independence in Practice

Clinical reasoning and decision making form key components of the MSc course and participants expressed their changed views of practice through discussions about these topics a great deal:

'..the clinical reasoning perspective as well, now I'm able to reason, er, reason out a lot more er, about the conditions - I'm able to differentiate between different conditions, on the basis of ar, activities they are er they are limited with and er other things, er, and other conditions, so my

clinical reasoning has improved after coming here and studying here..' Kevin 1

'..you have good ... understanding and actually your own thinking is that important, ...[s]*o actually you can stand by your own therapy independent*[ly]..' Kunjan 2

Sue for example considers critical reasoning (discernment) as a key skill, not in terms of a theoretical construct of clinical decision making, but as a means of deciding what might be useful in different contexts:

'..I think it's not about being opinionated about everything, and that's what I mean about being open minded, but at the same time discernment is important because not everything is good, in any context, not just the UK..' Sue 2

Clinical decision making represents a conclusion to clinical reasoning, and is seen as generated through the application of professional knowledge systems (Grimshaw & Sears, 2008). My analysis suggests that agency can be seen as contained within the independence of decision making inside the therapeutic arena and the autonomy of clinical decision making relates to professional power. In this way 'independent clinical decision making' forms an expression that sustains a narrative of agency. However it has already been demonstrated how this situation is likely to be challenged in practice, and the perceived difficulties were located particularly in India:

'..I'm just trying to compare to how it is to the UK, in the UK it's, it's more about learning at university as well [as] *learning on placement, and sort of, erm of it's a practical application of theoretical knowledge, but in India it's, it's more like its dictated rather than implementing your own reasoning skills..'* SB 1

Decision making in physiotherapy practice is curtailed in India by medical practitioners and all participants talked about relationships with doctors as holders of significant structural power over treatment. This is enshrined in Indian law, which locates professional control with the referring medical doctor:

'..the whole business of recommending physiotherapy, and not dictating treatment, is well, doctors in India they do tell you what to do..' SB 2

In this way independent clinical decision making in India is seen as practically impossible with consequent limitation in agency envisaged when participants return there to practice. The dominance of practice by medical staff is well recognised and open challenge to a doctor's clinical decision is deemed impossible:

'..you just blindly do what you're told..' Nick 2

And participants are all too aware of the lower status they hold:

'..the doctors, they don't consider physiotherapy as you know, a professionals sort of like they, they cons, er, ...they don't rate us highly..' Kevin 1

The challenge to autonomous practice experienced from the paying patient is echoed again in the structurally determined limitations to agency:

'..a good physio should take their own decisions not what they're told to do, like if I'm told to give some ultrasound, I mean, if I don't think it's gonna be effective I should stand for it then, I mean not fight for it, but I should make them understand, the higher authorities, that is not um something that you should give, I mean, I know better technique that can be helpful from my experience and from my practice..' Sam 1

But the appetite for conflict is low, and later Sam appears to change her mind as she says:

'..I was asked also sometimes by the doctors give SWD (short wave diathermy, a treatment obsolete in the UK), you can't go and argue with them that I'm not gonna give it. So if it's told to you then yeah, you have to give it..' Sam 2

In India, practitioners in public health settings can be expected to see up to fifty patients a day, a feat that is only achievable with the application of modalities. The limited time available in such a context generates clear tensions between England and Indian constructs of practice. Participants' new identifications with practice require time to assess, discuss with patients and make decisions. Here

Kevin considers how he will adapt his England learnt approach to enable him to use his skills:

> *'..I'm gonna apply it er, step by step, I'm gonna f-first of all start, start intro-introducing the observation part, like, instead of 45 minutes [as I might have in the UK], I'm gonna reduce, reduce it down to 15, 20 minutes maybe, that would be thorough observations, subjective or objective, ...and the patient may understand it, like, for the start they may not, they may think it as a burden, like why, why we are taking so much time to start the treatment, but with time they would understand that it is for their benefit..'* Kevin 1

Here Kevin bargains a shortened functional assessment (as compared to that he would be expected to do in England) with patients in India, almost considering this practice as something for him, rather than the client. He considers how much time might be taken from patients for his personal meaning making and internalised clinical reasoning, rather than striving for the impossible more apparently overt decision making that would be expected in an English situation. When considered from the perspective of the shared ownership of this therapeutic engagement this creativity emerges as something isolated from any wider meaning that might be generated in collaboration with the patient. Patient centred care, so enshrined in UK practice constructs, begins to look rather different in this new context. However it does generate meaning for him and, despite the greater hierarchical differences expressed within and between professions (see section 5.5.2 below), the nature of practice in India and the apparently low decision making capacity allowed, it can be seen that small and individual changes might be possible. Kevin claims 'time ownership' in the therapeutic engagement as a means of professional power exertion and in doing so forms a new, agentic and creative, cultural response.

Patient expectation makes UK forms of practice difficult to apply in India. Kevin has offered a practical solution to issues of transferring practice. Nick also recognises potential conflict but this time with colleagues. He views this positively, but he also recognises the need to address structural issues,

presenting his ideas for change to his colleagues and the organisation in which he works:

> *'..the education system here and there is different. Maybe the way I look at patients after my post-graduation and the way I treat them may be different from my colleagues who will be there. But I, I think so I, we can work that out and I can learn something good from them and they can learn something good from me..'* Nick 2

And so the need for transcultural, transferable skills emerge, in the abilities to present the new and to mediate during the conflict and difficulties generated. And it is these transferrable skills of negotiation and discussion with a range of people – patients, medical staff and physiotherapy colleagues alike - which will perhaps prove more significant than new specific treatment skills gained.

> *'..I have learned that technique to er, bring my idea to someone by not offending them, like putting it forward in a way nicely..'* Sam 2

But confidence is necessary to do this, further supporting this as an important factor in practice and the inter-relational nature of identifications and agency.

5.5.2 Professional Hierarchies in Physiotherapy

Participants felt that treatments were dictated not only by patients and doctors, but also by the rigid hierarchy expressed in physiotherapy departments. The expression of this was again through the control of clinical decision making:

> *'When I was working under a senior physio I was just told to do this and do that..'* Nick 2

There can be tight control by the lead in any specialist area, but the framework for working relationships in India are generally not formalised through job descriptions or detailed contracts, but instead generated by and through job titles, personal contacts and working interactions (Khare, 1996). The lack of formal constructions relating to professional status created by complex, unregulated, health practices leads to a foregrounding of the importance of personal links to colleagues. It is through these informal mechanisms that professional agency can be generated:

'..you need to build some relationships with the people that you work with and that, and that allows you some freedom to do some of the things that you'd like to do that you, that you feel are beneficial..' Kunjan 2

Perhaps the freedom felt and expressed by participants was in part a consequence of the wider arena, the psychosocial contexts and relational aspects that they now could consider as part of their treatment thinking. Seniority brings some expectation of treatment autonomy for participants:

'..if one is a senior physio under the HoD [Head of Department] *then we have all the time to do what we like. There's nothing as er half an hour or one hour appointments per, per patient, so ah, we can execute all possible treatments, so there is autonomy there in terms of time and er, flexibility and er you know, arranging all the treatments based on one's own convenience..'* SB 1

And so agency can be established in departmental working despite a medical presence, through personal relationships and allegiances as well as the structural hierarchy offered through the employing organisation. Here Kevin thinks about using his M level status as a means of advancing practice, as working at a senior level also offers some scope for negotiating a better position:

'..I'm hoping for to go for a senior physiotherapist jobs, so that I could, I could at least apply these sort of things in my, in my post as a physiotherapist, I could ask them to do that, and er, I could be at some, you know, some level to, to talk to the managers, to say that this is effective for you and you should apply this, at my res - I'm a senior physiotherapist in the hospitals, you should try to listen to me, try to understand me..' Kevin 2

Smaller locations offer scope for some independence, as a hierarchy is only rigid where it is present. Therapists in India commonly hold multiple employment positions in different working locations, so particularly in the smaller, private clinics, senior members of staff are absent for long stretches of time, leaving younger and less experienced members of staff to work alone:

'..the senior physio was there, previously, but after that er he left everything on me ... I worked independently, he used, er, he used to come like er, once in a two week time, he used to look at the patient reports and all, and er otherwise I used to do the treatment, I used to analyse the patients..' Kevin 1

5.5.3 Employment Arena as a Means of Claiming Decision Making Control and Agency

When discussing with participants their potential future roles and working options, they generally favoured employment areas where conflict could be avoided i.e. places devoid of the overwhelming dominance of doctors or patients. In this way, freedom to practice is related to the choice of specialisation, which is the focussing of skill in an area of practice. All the participants were undertaking the musculoskeletal route of the course (see section 2.1), and a popular career route for this speciality is working in private practice. Musculoskeletal practices tend to involve the soft tissues and are relatively minor health issues, frequently uncomfortable or painful, but not life-threatening, so consequently they tend not to require the involvement of doctors, other health care professionals or hospitalisation. Their treatment is less open to observation or scrutiny by others especially if occurring in a lone working, private practice context and this allows physiotherapists to practice with greater levels of clinical autonomy in India than that specifically permitted by law.

'Now I'll be working on my own maybe so I'll um inculcate these things [manual therapy] into my practice..' Nick 2

The potentially lucrative area of sports therapy was another area of interest:

'I want to be a well-known sports physio, and er, (sigh) I want to, I want my own set up..' Kevin 1

The recent growth of India's economy and the expansion of the sporting industry (Shilbury & Ferkins, 2011) have led to increasing professionalisation in sport. This affords both therapist and professional sports player opportunities

for new ways of engaging and the potential for synergistic working. Physiotherapy has become an automatic aspect of any field of professional play (Bulley & Donaghy, 2005) opening a new arena for independent working and a further form of professional 'shelter' away from the usual holders of medical power (see section 2.5.1). However the power of the paying patient (see section 2.5.2) remains:

> *'..there were a few things, first thing they [international cricketers] were not very much familiar with the role of the physiotherapist and, er, I think if you are [the cricketer] at a big stage, ... so you get that attention, you get that rehabilitation, you get that er, ... you [the cricketer] get what you want..'* Kevin 2

Traditional medical hierarchies are being challenged by the potential freedom to self-determine practice by working outside of public medical practices. Physiotherapists, influenced by the professional narratives of clinical reasoning and independent clinical decision making, search for more opportunities for autonomy. And more independence occurs in both private health care, where outside investment has brought many international health care practices to India (Bhat, 1999; Sahni, 2014), and in the sports arena, by involvement with international sports. The potential effect of this engagement in musculoskeletal and sports therapy is that patient self-referral to physiotherapy, endemic in Indian private practice, has resulted in an uneven distribution of professional opportunities in those areas of working. Other speciality areas in physiotherapy, such as neurology or respiratory care, perhaps do not have the same professional status, because they tend to still only operate within the mainstream, regulatory processes.

The location and the type of work that participants chose to do strongly relate to their perceptions of independence in practice. Several participants said that they would like to work in England or anywhere in a better resourced country. But for most participants, perhaps recognising that there was a lack of realistic opportunities, secondary to visa restrictions or cost (Horobin & Thom, 2015), detailed employment discussion focussed on working in India. Private clinics in India were perceived to be the best working option for graduates, as private patients tend to present themselves directly to physiotherapists for treatment

rather than pay a doctor for a referral. The private physiotherapist thus evades medical intervention and control, and participants appeared to intend to hide from, rather than directly subvert medical authority:

> *'..so in private clinic...if you get back pain, neck pain, go through the direct physiotherapy, don't go through the orthopaedic [doctor] because they refer same thing ... for the physiotherapy also..'* Kunjan 1

Independent practice 'under the radar' appears attractive:

> *'..like in there, you have to set up your own clinic..'* Kunjan 2

However, it is not necessarily that easy to establish a successful private clinic or to escape medical gaze. A certain level of status is required to launch an independent career. The participants would do this on returning to India having had very little clinical experience as a qualified practitioner to draw upon and only modest levels of status:

> *'..you need pro.., professional contact also. You require lots of, er, references from the orthopaedics, ... we have to negotiate with the peoples and patients..'* Kunjan 2

Contacts in the right places would help establish business and the 'references' mentioned (although not explicitly stated) might euphemistically relate to considerable amounts of purchasing power, in order that he could initiate such a clinic 'legally'.

5.5.4 Self-Direction of Learning as an Expression of Agency

Participants define themselves as being on a quest for professional development (French & Dowds, 2008). Given that knowledge constructs form an important aspect of professional identification, then decisions made around what to study become an area where professional agency can be expressed. The desire to 'know more' acts as a strong stimulus for participants to come to study in the UK, and the self-confidence required for practice is enhanced by the self-belief gained from this further study. Despite the evidence of cultural hegemony in the acquisition of practice techniques, learning also extends into the metaphysical, relating to their level of engagement in their work. The

narratives suggest that study and the self-development that results are important mechanisms by which participants can enhance their status and effect influence within work contexts. Given this, it is unsurprising that the concept of Continuing Professional Development (CPD) emerged strongly within participant narratives (notwithstanding that it also formed a part of the course narrative) and notions of CPD were woven into the meanings of other constructs and identifications.

Participants feel that they have developed, or are continuing to develop, personally and professionally. In addition to gaining the confidence to express their own constructs of ideas to patients, they have learned to value their own research, their own independent thinking and clinical reasoning and belief in themselves through a sense of finding their own voice on issues.

At a personal level, knowledge is seen as a pre requisite to professionalism:

> *'..so if 's if you doing a professional job, er like professional job, so it's like con, constant process of knowledge in an pr.., physiotherapy. So er there's a good thing to keep constant er up to date to the knowledge of in the modern times..'* Kunjan 2

Sue demonstrates the personalised adoption and integration of learning into the search for meaning in practice. Continuous effort to engage with theory to enhance performance is suggested to be essential as not only a moral pre requisite, but one that also ultimately benefits the participant and the profession:

> '[a professional is] *someone who's.. previous experience, knowledge and skill is reflected upon their current practice and someone who never stops learning, but who constantly goes on wanting to ah, know more, get better for the sake of not just their patients, but for the sake of their profession as well and someone who is passionate about this profession and then am, wants to constantly improve it, or ....develop it in any sense, so someone who's, who doesn't stop at one point and say I've done much, I've done enough and I don't think that there's anything*

more, but then doesn't stop at that point but then goes on further than that I think it's an evolving process..' Sue 1

The relationship between knowledge development and critical awareness is seen by Kunjan:

'..but actually it's quite helpful to get er good knowledge .I.. if I talking about my er 'n er.. present[ation] *in front of er two hundred er student, so if .. one professional opinion different of some conditions, but actually they merge together and you can actually get them different, different perspective and knowledge so actually you can go in-depth in that, in in-depth information in that. So 't, if you do critical thinking you can get actually good knowledge ... in that, not superficial knowledge as here he say that like, like er ...*

H: That's a really nice, that's a really nice thought. Um, so critical thinking leads to deep, deeper ...

K: Deep, deeper understanding..' Kunjan 2

This description of collaborative study helps shape the depth and criticality of Kunjan's thinking, implying that it is not just what is studied, but how it is studied that has an impact: the methods of teaching as well as the content relates to student development. Indeed independent study and coping with complexity is critical in developing new skills:

'..the thing that I liked most is er, you, you are on your own, you need to work (H: you liked that?) yeah, I liked that, you need to work out how you can, you can enhance the knowledge, er, it's just, it's just that er teachers can guide you, but in Masters you're responsible for your own knowledge in and if, if you want to be a successful, then, you should take that responsibility..' Kevin 1

The capacity for self-expression generates a sense of professional responsibility and autonomy in learning:

'I think that's why I said that I've learnt how to learn because if I don't know about some it doesn't stop there, I've, I've been taught to, go search, find out..' Sue 2

The quotations above have given a brief overview of how the participants recognise and respond to the responsibility for researching and developing their own thoughts on clinical issues. They demonstrate interrelationships between notions of meaning as well as the control of learning. These metaphysical aspects of learning also become an expression of agency in the professional lives of participants.

5.6 Professional Practice: A Model of 'Engagement'

Using the term 'active' to describe newly considered approaches to treatment is misleading since it only partly describes the direction therapeutic ideas have taken. But another disjuncture is also exposed in the narratives because, whilst they explain practice in terms of action (or its absence - 'active' or 'passive') it is clear from the discussions relating to power, status and symbolic treatments, that there are nuances and influences contained within the therapeutic relationship that are not addressed by the active-passive model of practice (see Figure 1, p. 135). These influences hinge upon power relationships, identifications shared, exerted and accepted. Descriptions of 'active' and 'passive' function only when applied to physical aspects of physiotherapy practices, and are insufficient to include the metaphysical components of treatments. The models of practice that the participants described and which are demonstrated in Figure 1 are perhaps still constrained by the positivistic thinking that has characterised physiotherapy practice since its inception.

An issue with developing a model of practice focussing solely on the physiotherapist is that it fails to recognise the relationship between the activities of both actors in the context of care, the patient and the physiotherapist. Figure 1 is based on the original statements made by the participants around active and passive approaches, but these ideas can be challenged and in this way generate a new interpretation about the nature of practice itself. Patients are

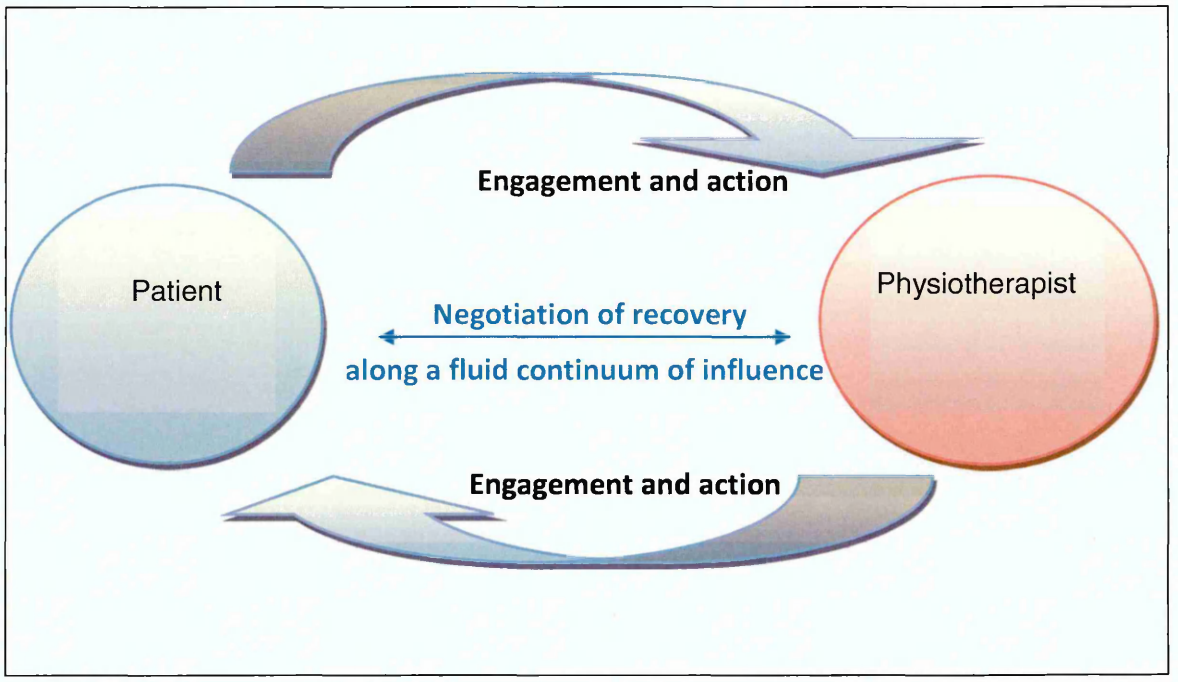
expected to be involved, and where patients might express opinions on what is asked of him or her, then treatments are negotiable.

These power relations between physiotherapists and patients are contextualised both by structural and individual factors (Sandstrom, 2006). On the physiotherapy side, the encouragement to assess patients fully and perceive clinical autonomy, along with decisions around CPD, becomes cyclical and self-fulfilling and generate cultural capital. The emancipatory ideas related to the use of evidence based practice (Jones, Grimmer, Edwards, Higgs, & Trede, 2006), generate an awareness of self and the development of one's own voice add to therapist confidence. Additionally the participants' narratives present the symbolic, professional power intrinsically held by physiotherapists through the treatments they offer and a recognition of the capital that patients exert through payment for treatments as well as their desires for treatment.

This involvement of the therapist 'self', as well as the patient, in practice supports the development of a dually engaged concept of physiotherapy practice. I suggest that a model expressing these aspects should not focus solely on the actors, their motivations and constraints, but instead on the performances which result from those contexts. Treatment could be defined in this way as a joint expression of activity. The joint engagement would then consist of negotiations around what the patient does for him or herself and what the physiotherapist does to or for them, to support recovery.

Figure 3 over the page represents this new model of practice in which the mutuality of engagement is represented. Treatment performance becomes enacted along a continuum of influence or power existent between physiotherapists and patients in different contexts. It is an engaged-performance model of physiotherapy practice, which, rather than relating action and inaction (passivity) of just the patient, acknowledges the varying capacity of therapists and patients to negotiate what is done by whom in practice. Local, national and global factors shape the influence and form the issues contingent in treatment contexts but this model is sufficiently flexible to represent practice in either country location.

Figure 3: An Engagement Model of Practice Diagram



Therapy as an activity of mutual engagement has been proposed previously by Lequerica and Kortte (2010). However they have not considered the sociocultural factors that might influence engagement and have only focussed, as is the norm with positivist approaches to health care, on the individuals, a stance that has already been shown to be limited.

Physiotherapists manage their clinical thinking and actions in an arena of tension between the physiotherapist's professional gain (professional cultural capital or its display, through confidence) by hands on or technical treatments, governmental or medical demands from the service, evidence that supports more exercise based approaches, and the wishes and beliefs of the patient. This new construct of practice encompasses differences and the fluidity of power relationships between patients and physiotherapists, where professional constructs containing symbolic power are retained by the therapist, and this remains true regardless of the location or style and technique of treatments. Indeed it may represent the nature of rehabilitation.

In this way, study on the programme is seen to effect cultural change by increasing therapist and patient engagement across the physical and psycho-social aspects of treatment. The participants recognise transferable skills in themselves, such as taking responsibility for oneself, independent and critical thinking as well as listening skills and managing one's time. In identifying these aspects of learning, participants reveal that the wider pedagogic demands exerted by the programme and assessment tasks are potentially more beneficial to them than the content of what is taught. Simpson et al. (2009) considered the MBA they delivered as a 'rite of passage' and whilst this might have some resonance for the participants, my analysis suggests that it depends on what one considers to be useful learning as to whether this is the case for Indian physiotherapists. It seems that to call it a 'rite' is to reduce the programme to a collection of experiences to be endured, whereas a more positive interpretation of the programme would recognise the importance to professional practice of the confidence and articulacy that emerges from those experiences of living and learning overseas.

5.6.1 Issues in Practice

A deeper understanding of therapeutic impact can only enhance practice. It is now pertinent to adopt the term 'expert by experience' or more simply 'expert', instead of patient since the latter is potentially demeaning (see footnote 2). The recognition of the importance of expert voices in our understandings of practice mean that including them is the only way to fully explore the meanings of our work and their absence in so much physiotherapy research becomes transparent.

Educational practices frequently refer to 'teaching and learning', where the tutor delivery and the student reception are considered mutually. So too might physiotherapy refer to its practices as 'physiotherapy' and 'the lived experience of physiotherapy treatment'. Such a stance would transform the viewing of physiotherapy, and give first order importance to expert views, something essential when considering the social nature of therapeutic practices. This perspective challenges the current positivist nature of the profession, which has,

in the past, tended to allow the dominance of professional constructs over expert experiences. For whatever reason, the profession does not yet appear to be sufficiently self-aware to permit much research of this kind within its professional boundaries and, without a robust methodological approach, such a stance has proved impossible. One can only hope that the maturing of the profession will bring with it opportunities to see the culture of its working practices differently and include those of other practitioners and experts.

Further discussion regarding this is beyond the bounds of the thesis, however it can be seen that through a consideration of power discourses in therapy, the positions of everyone within the therapeutic arena are exposed and power imbalances revealed.

5.7 Chapter Conclusion

Exposure to English pedagogies and assumptions about physiotherapy practice generate an understanding beyond the acquisition of knowledge and skills to include identity effects of development and change, transformations as individuals negotiate tensions and ambiguity (Lincoln, 1997) that relate to practice.

In this chapter I have discussed the narratives of participants as they describe the different working identifications they see in practice in India and England, and what appear to be cultural differences embedded in teleological, governmental and financial contexts which act to define the actions of physiotherapists. Identifications reveal the power dynamics within the therapeutic arena, created and controlled by both structural and symbolic elements. Participants adopt the terms 'active' and 'passive' to define some aspects of these power relationships, but these terms do not recognise the potential authority of patients or the complexity of the patient-physiotherapist interaction, rendering them of little explanatory value.

Agency within physiotherapy is explored through the management of the

symbolic elements of cultural capital in practice. Conflicting theoretical constructs produce different levels of power disparity and subsequently diverse practices. This represents a tension within physiotherapy and the resolution of this tension brings communication between patient and therapist to the fore in the therapeutic engagement. Confidence as an integral aspect of treatment performance, along with self-expression, forms a narrative of a balanced and engaged interplay of power during practice and this is used to consider how practice is shaped and performed.

Varying levels of perceived professional autonomy emerge from the narratives as experienced by therapists at different times, depending on the level of medical supervision/interference, stage of career, position within the hierarchy, location, and size of department and financial or ownership position. Participants, when faced with apparent restrictions around clinical decision making seek to avoid conflict and enhance agency by finding work opportunities that maximise their freedom. Relationships with patients and self-direction form an internal dimension to a sense of agency within the therapeutic encounter which adds a metaphysical dimension to practice. Participants recognise that the self-expression and critical thinking that are required as part of the course bestow a form of liberation and freedom of thought and self in personal and professional lives.

I propose a model of working from participants' understandings and how practice is seen to be constructed as a result of the programme. This model of practice transcends any apparent differences between English or Indian working practices. It offers an approach to patients that depicts physiotherapy as relational, rather than 'active' or 'passive'. Building on this understanding of power within therapeutic relationships and I conceptualise a theory of 'engagement' of both patient and physiotherapist that is adaptable to different socio-political contexts.

In the next chapter I address the implications of this for in teaching and learning.

6 Chapter 6. Pedagogic Considerations

In this chapter I take the participants' descriptions relating to their learning and through continued ethnographic considerations, I conceptualise the potential meanings relating to the course pedagogy. I also view the cultural dominance within the teaching environment and critique this through critical race theory. I go on to discuss some of the implications for practice and teaching in HE as a consequence of these issues.

6.1 Introduction

I now inductively build theory from the analysis already outlined in Chapter Five. Having identified aspects of the cultured worlds, I continue work with these ideas using ethnographically informed thinking to explore their implications and meanings for cultural worlds within which they were generated. Through the participants' identifications I have a mechanism by which to assess the impact of the meeting and combining of cultured worlds. These considerations form the search to answers in relation to my second research aim (see p. 30) of what can be said, with the understandings generated from Chapter Five, about pedagogic practice.

During the analysis, as I considered what the participants had said, and as I searched out explicit practice information, implicit issues in these cultured worlds became visible. Gradually participant identifications as members of working, teaching and learning cultures emerged and they included work related structures, power dynamics as well as the assumptions that constrain and define the cultured worlds of physiotherapy practice, teaching and learning (Holland et al., 2001). I consider the teaching and learning environment of the course as 'professional teaching'. This is exemplified by the failure to appreciate structural issues relating to practice contexts, which results in an inherent negation of the value of Indian practices. The MSc course creates hidden meanings and, as a consequence, these result in unrecognised corollaries. In the same way that I interpret identifications outlined by individuals to develop

insights into a shared world or practice, so are their shared perspectives joined here to comment on a shared world of learning. Subsequently I consider the implications for practice and for HEIs in the light of these ideas.

6.2 Professional Teaching - Cultural Dominance

The participants have relocated geographically, educationally, culturally and linguistically. In liminal terms, participants have crossed and are located between physical geographical, as well as cultural, boundaries - suspended between social structures (Rutherford, 1990; Simpson et al., 2009; Turner, 1993). They experience the fragmentations and interruptions of postmodern relationships – captured by Bauman (2013, p. title) in his term 'liquid modernity'. In response to the potential overwhelm generated by the complexity of the postmodern condition and the limitless possibilities of what they might become (Gergen, 1991; Lyotard, 1984) the students appear to adapt wholesale to English cultural expectations. In response to the challenge of fluidity and personal disintegration that potentially results from the experience of a transcultural education course, the participants become enveloped in English cultural worlds (Gabriel & Griffiths, 2008) to the extent where all but one of them choose English names to represent them and their discourse in the interviews.

The strength of English identifications expressed by participants then raises issues of how these emerge. It has already been noted that international student learning is frequently viewed through the contexts and discourses of the well-resourced nations (Sheridan, 2011), and participants, conforming to the unconscious expectations of the programme, adopt English identifications. The notion of cultural dominance in English HEIs has already been explained, where differences between traditional and non-traditional students form a dichotomy of 'us' and 'them' (see section 2.6.2) (Apfelthaler et al., 2007). My own history (sections 1.4.1 & 1.4.2) sensitised me to become aware of this division on the course and of a negation of Indian students' prior learning and practice.

6.2.1 Cultural Hegemony Explored in terms of Active and Passive Terminology

As I reasoned in Chapter Five, cultural differences between practice in India and England are not represented by the terms 'active' and 'passive', but instead merely by the kind of passive techniques employed. The high prevalence of these terms within the narratives as well as the participants' exclusive representation of themselves as becoming 'active' in their practice having previously been 'passive' is testimony to the dominance of these views within the programme as well as the strength of the participants' identification with them. The wholesale labelling of Indian practice as 'passive' and English practice as 'active' negates the wide variations in UK practice and positions Indian physiotherapy as 'inactive' and 'acquiescent' in the face of 'assertive' English practices. By suggesting that Indian therapists become 'active' and are thereby freed from a past prescriptive (passive) behaviour and are now able to make (active) clinical decisions is fundamentally flawed, as Tran (2011) suggests, since – as I argued extensively in Chapter Five - the key differences between cultural practices lay within the structural formations that surround them and the limited agency in physiotherapy practice in any location is dependent upon these structural constraints.

Within the MSc course there was a structural acceptance of the dissemination of these terms. The monocultural perspective promoted thereby 'normalised' English practice and through doing so exposed a cultural power dynamic. This vision of English practice tends to render it static, and thus it becomes not only invisible and dominant, but unchanging and homogeneous (Ladson-Billings & Tate IV, 1995). Such an approach acts to form a reductionist view of physiotherapy practice, which recognises only distinct national cultures and where people and practices in one cultural perspective are seen as essentially different from another (Holliday, Hyde, & Kullman, 2010).

Acknowledging this opens discussion in relation to the power discourses that shape and change the educational context (Edwards & Usher, 2008). These culturally pejorative terms (active and passive) seem to form a hidden element

of the curriculum (Kentli, 2009). The net result is that the English profession is elevated and the Indian version is undermined. In taking this stance towards others, tutors risk these generalisations of 'passivity' becoming stereotypes, ways of seeing Indian physiotherapists that group them to set of negative characteristics. The attitude that Indian practice is 'passive' positions the participants as 'deficit' when viewed through our own thinking in relation to cultural practices and there have been consistent voices arguing against the consequential oppression generated by these kinds of categorisation (hooks, 2014).

Within an environment where perceived national cultural world views of practice and learning dominate, the cultural practices of international students are inevitably and systematically devalued (Baskerville, 2003; Shen & Pedulla, 2000). In positioning other cultures as lesser and the labelling other practices as 'deficient', the course now hardly appears emancipatory, and indeed could be viewed as oppressive (Illich, 1978). Through inadequately addressing or acknowledging the power differential exerted by and through culture (Madge et al., 2009; McKenna, 2004; Rizvi, 2007) the course could be described as 'post-colonial' (Grimshaw & Sears, 2008).

Physiotherapists coming from India have not had the same professional socialisation, either formally through their education or informally from their peers and their community. The transformation process of an 'Indian' to an 'English' physiotherapist is arguably an acculturation process during which the values, norms and symbols of the profession are internalised (Toit, 1995). Their personal struggle for meaning and understanding in relation to norms of practice and the very discrete actions of and between individuals suggests that a deep understanding will not be achieved using an approach modelled solely in an 'active-passive' hierarchy. Higgs and Hunt (1999) described a profession as a constant dynamic rather than an achievable goal, and one role of education should surely be in raising awareness of the various contexts involved in shaping professional functioning.

Subconscious, culturally derived prejudice might be a reason for the frequent failure of HE staff to recognise their impact on the difficulties students from other cultures experience (Bowl et al., 2008). In a similar manner to Hofstede (Baskerville, 2003; Hofstede, 1984) who developed a system of national indices on which to manage business relationships, the MSc programme has developed its own language of teaching engagement. These narratives of 'active' and 'passive' in the face of their over simplification of existent practices suggest that, within the teaching context, the English course team adopt a dominant position in relation the physiotherapy practices that occur in India. Symbolism has been considered in the context of physiotherapy practice and this could extend to the notion of 'passivity' in cultural engagement given the context of the UK's colonial history with India. See Figure 4 below, for an example of an image from the mid-1800s: revealing the dominant stature of Queen Victoria and the subservient Indian, in a symbolic representation of strength and power.

Figure 4: The Accession of the Queen of India

From Graves (2014)

The word 'passive' when applied to Indian practitioners, when viewed in this historical context is particularly troubling. The uniform viewing by the participants of themselves as previously deficient, their total acceptance of English practices despite their recognition that these cannot easily be

transferred into their working environment in India and their embracing of English culture, can, in large part be attributed to the delivery of the course curriculum as I understood it. It did not allow for expansion of prior knowledge, but instead presented a completely new framework for understanding practice. When considering critical race theory, which suggests that racism is socially constructed (Gillborn, 2006; Ladson-Billings & Tate IV, 1995), this new framework can be seen as a form of white supremacism, however unintentional this may be (Solorzano, 1997).

6.2.2 Uncertainty in Assessing the Impact of Hegemonic Discourses

Nearly all of the cross-national education research I have considered refers to the experiences of students in HE, however, results of research into socio-cultural impacts on health care workers also sheds some light onto the potential experience of physiotherapy students on graduating and working in England. Allan, Larsen, Bryan, and Smith (2004) noted the centrality and institutionalisation of racism in the experiences of internationally recruited nurses working in the English health care system. Whilst nurses engage in different sociocultural practices, this may nevertheless indicate the extent of prejudice in some parts of the NHS.

The positioning of the 'other as less' equates to an oppressive practice (Solorzano, 1997) and this consideration forms a basis for critical race theory (Ladson-Billings & Tate IV, 1995). This perspective is not well understood, particularly in health care education, despite great efforts at supporting and engaging in issues of diversity in health care education (Beach et al., 2005). These efforts frequently take the form of cultural competency development for students, but this has been criticised particularly by Queer Theorists (another area of academic writing about marginalised 'others') as superficial at best and maintaining the issues of privilege and dominance at worst (Baker & Beagan, 2014). One of the difficulties is that this research revolves around perception, an issue that I address in Chapter Seven, section 7.4 when I consider the limitations of the research.

The positioning of the 'other as less' is seen by race academics as a form of racism that disempowers the minorities affected by it, adversely affecting confidence (Solorzano, 1997). It is easy to see that participants' identifications around the lack of worth of Indian practices, could become a recipe for dissatisfaction and discontentment for Indian practitioners. So, paradoxically whilst the course acts to enhance confidence in their work in one respect, confidence in themselves might also be diminished. It is no wonder that participants do not see themselves returning to work in the same environment as previously. They return to India at the end of the course, having adjusted to English working ways and appear to be lost to public health services in their home country. Their aspiration is to form islands of difference, alienated from their original health or even wider social cultures. It not possible to know what the impact this might have on participants in the longer term, let alone the knock-on effect on patients, but in an arena of uneven power distribution, the ripples of advantage and disadvantage spread outwards and it is not only the participants that have much to lose in relation to health care services, but also patients and their families too.

We have very little idea about what impact participants' emergent practice understandings will have in reality or what happens to them as the alumni return home. Not only are student perspectives during study in England under-researched, but, as Brown (2009b) notes, even more so their perspective on returning to the home culture. But recognising that re-entry to the host country is difficult (Volet, 2004) and the nature of the course now exposed as culturally dominant, it is appropriate to consider what the course impact could be. Given the negative construct about practice in India afforded through the programme and the difficulties that participants predict with regard to changing practice in India, it becomes easy to see that returning home might prove depressing or distressing to graduates. Certainly, during my time as lecturer, students have frequently discussed with me fears and anxieties about re-entry to their home country.

Sennett and Cobb (1973) in their seminal book on class mobility note the distress generated within those who, as a consequence of their work, rise within

a class based environment. It creates unease and sometimes unhappiness, through conflicting identifications rooted in their beliefs about themselves and their worth. Projected identities that are internalised can form deep seated senses of 'self', as I have experienced through my failure of the 11-plus, and the challenge to my future hopes formed by Neville, the mastic asphalt spreader. These identifications can resonate widely and profoundly in people's lives. The participants in this research can be considered to be on a journey from one cultural perspective to another, and it has been noted previously that development is not confined to the classroom, but takes place in a diversity of life settings: in relation to personal identifications and other psycho-socio-cultural contexts (Edwards & Usher, 2008). A sense of alienation from home could be a consequence that Indian physiotherapists face, through the implicit negativity of an externally projected and internally accepted, identification to an inherent lack of value or merit.

It could be suggested that the programme is required to promote itself as superior since it takes place in the international market place for HE, where credibility and status are bought. Kevin, reveals this view:

> '*..if you do your Masters from a reputary university, then you are being considered er, as er, as much more knowledgeable, because of that reputation of the university, ... you are reputated highly if you do it from a reputary university..'* Kevin 1

Telling participants that what they are learning is 'better' forms a necessary part of the merchandising of the programme and it is well understood that student promotion of programmes is the best and most effective form of marketing (Russell, 2005). Micro power dynamics are features of all locations (Foucault, 1988) and the education export industry could even be said to thrive as a consequence of these power dynamics, with students drawn to the status inherent within the globally positioned, hegemonic English system. In section 2.6 I note the success of the education export industry in economic terms, but also demonstrate a lesser capacity of research to evaluate either pedagogy (Tran, 2011) or the transfer of culturally bounded practices (Volet, 2004). But this hinges on how one defines 'better': some aspects of study could be said to

advance practice, that do not involve positioning the previous treatments people had engaged in as 'lesser', such as the increased shared communication and diversity of treatment options.

Having recognised the influences of power discourses, it now becomes pertinent to consider suitable responses to these issues.

6.3 Implications for Profession Teaching and Learning

Much has been written relating to cultural adaption and cross-cultural identity and indeed there are journals devoted to this (for example 'Race, Ethnicity and Education' and 'Intercultural Education'). The impact of issues in teaching and learning on physiotherapy working practices are not readily discernible from the current discussion, as they occur within a university rather than a practice setting. But the non-applicability of English practices to other locations and the level of implicit cultural oppression experienced by participants within the course is a cause for concern in relation to the future working contexts in which they find themselves. This challenges the course to consider anew the monocultural approach it had, and to strive towards an internationalised curriculum, which would not only involve the respectful engagement with other practices but also greater awareness of the structural issues that contain practices, including those in England (Haigh, 2008).

6.3.1 Issues for Higher Education Institutions

Despite enrolling over 4,000 international students annually, the university's strategic plan for 2008 – 2013 reflected only a market appreciation of these students through its requirement for higher numbers to enrol and it appeared to ignore the concept of internationalisation of the curriculum (see section 1.6). This marketised, rather than pedagogic, approach is not unusual according to Tran (2011). If worldwide perspectives on practice were not a priority for the university it is not really a surprise that neither were they for the programme. The limited internationalisation in the strategy appears to relate more to the anxieties generated by other current pressures in the English HEI arena, for

example the National Student Survey, which indicates that home students are often not keen to integrate with those from outside the UK (Peacock & Harrison, 2009). The university is very sensitive about these results since they strongly influence UK HEI ranking systems, and a fear is that a strong focus on integrating their international cohorts may affect ratings further. This, to me, is a short sighted view – if home internationalisation were to occur through internationalisation of the curriculum, then all students would gain from learning more about other cultural perspectives if teaching was approached in an inclusive way (Carroll & Ryan, 2007).

Students from a less well-resourced country come to study in the UK at a high cost. I would argue that, ethically, the course should help international students understand their own context, in addition to learning alternative practices, in order to make constructive decisions for themselves. This requires a degree of responsibility in the way we offer education to students from elsewhere and for us to be ethical in terms of our organisational practices. It is particularly important that HEIs act with awareness of these issues and the wider context of brain-drain/brain-gain (Altbach & Knight, 2007).

Transnationally situated education occurs at the boundaries of professional identifications and, when developing curricula, HEIs need to be sensitive to professional needs for cohorts likely to engage with diverse and/or pluralistic societies. The content of the physiotherapy programme is almost entirely focussed on English clinical practices, so the privilege given to the dominant cultural discourses, their largely unreflective search for control and the prioritisation of a Western based model of practice and education pedagogy forms the basis for Grimshaw and Sears (2008) suggestion that any research that takes as 'normal' (i.e. ignores) the cultural base from which it emerges is neo-imperialist in nature. A critical framework has allowed me to view the conditions that serve to disadvantage and discriminate against cultures, including Indian, such as hierarchy, hegemony and racism. Students are exposed to a white authority, in the form of an English university, and it promotes the hegemony of English practice with its ethnocentric views and oppressive attitudes.

Higgs et al. (1999) rightly predicted increases in education for international, migrant physiotherapists as part of the global developments outlined in the introduction. This trend can be seen in the uptake of post graduate physiotherapy education programmes in the UK. Between 2007 and 2012 there were increasing student numbers on the MSc course subject to this research, rising to a peak of over a hundred in 2010-2011. At the same time the number of UK HEIs offering full time PG physiotherapy courses aimed at the international market also increased[23]. However, a change in administration to the coalition government in 2010 and the new Department for Education's altered focus in the education strategy, as well as political tensions around the number of immigrants allowed to enter the UK, prompted the effective loss of the post study work (PSW) visa scheme. Graduates are now required to have visa sponsorship through a professional post within 3 months of graduating. This stipulation results in little time for adaptation into UK working culture and practice and excludes many physiotherapists for whom the on-going cultural adaption takes more time.

Adding to the pressure on job finding for graduates is the fiscal restraint introduced by the current government for the NHS following the 2008 banking crisis and the austerity policies of the coalition government (Bidgood, 2012). Reduced or only maintained government spending in the health arena has resulted in severely limited job availability in health service areas (Prince, 2011). These issues have combined to generate a twofold impact: reducing alumni's capacity to gain employment (by offering them much less time to find and prepare for work) and simultaneously increasing the competition for positions.

The overall impact has been that UK job finding for alumni has become not just difficult, but virtually impossible. They are now expected to return home or move to a third country on course completion. The decrease in numbers entering the UK secondary to changes in immigration regulations has disproportionally affected Indian students, perhaps because of the critical importance to this group of work opportunities in the UK following graduation

[23] From 3 HEIs in 2005 (from an internal market intelligence report at that time) to 28 in 2010 (The British Council 2010).

(Williams, 2013). So, whilst the number of international student visas administered continues to rise in the UK overall, this data hides decreases in the number of study-related visas issued for Indian students which fell by 21% in one academic year (UKVI, 2014). This is reflected in the admissions to the physiotherapy programme which dropped to around 20 in the academic year 2013 - 2014.

This heavy focus on UK employability comes not only from the students but has also been influenced by the university's 'employability agenda', where career development is stated to be an essential aspect of all courses. This is particularly relevant for a university with a history rooted in professional qualifications, but also within physiotherapy pedagogy. It is accepted that the purpose of learning is to *be* a physiotherapist, and this includes all the culturally accepted norms that this professional position carries with it. And it can be seen that initially physiotherapists who travelled to the UK to work in the UK, improved their access to jobs through having Masters level study. This shaped the course to bridge national boundaries and practices (Williams et al., 2012) and as a result it focussed on English practices as a model of working. Now, however, students on the course are intending to return home, or elsewhere in the better resourced world, with the attendant complications that it generates in cultural and professional transition.

From this background it can be seen that there are business as well as pedagogic rationales for greater levels of cultural flexibility in approaches to teaching about practice. If the university is to maintain a programme that is attractive to students then it must offer them something that can help them develop practice in a variety of locations. This requires a curriculum that is fit for a wider variety of final locations and this could be achieved through proper internationalisation of the curriculum.

6.3.2 Staff Cultural Competency and Development

Helping staff develop broader cultural views is challenging. Nicholls (2012) has suggested that physiotherapists tend to develop firmly fixed professional

identifications which generate a construction of professional practice with little flexibility. This perhaps forms one reason for the poor uptake of staff development sessions to enhance cultural competency, with some staff not recognising the need or value of the sessions offered. As well as fixed professional identifications that tutors may have, those that most need to alter their perspectives appear the most resistant to do so (Rutherford, 1990). Perhaps too the cultural dominance of English physiotherapy styles of practice and the consequent sense of secure identification attained by feelings of cultural superiority over a less well-resourced country, contribute to people's resistance to change. Key to change is increased sensitivity to the power discrepancies that exist within the teaching arena and the repositioning of students as of greater value. These would allow the achievement of greater depth of understanding (Ward & Kennedy, 1999). Student or problem focussed teaching, perhaps involving student researchers, could be utilised to share global professional knowledge as individuals offer a unique insight and access into the experiences of this student group. Indeed physiotherapy as a whole needs to be more 'self-aware' so that it may both recognise its cultural constructions and be more sensitive towards them. This is true not only for understanding issues of diversity within the profession but also within the practice relationships that it has with service users.

Staff engaged in developing teaching practice are then challenged to offer opportunities to tutors that encourage reflection and self-questioning and to facilitate staff to recognise their own potential areas for development. Ultimately though, without a university strategy and a strong institutional commitment towards internationalisation for all students, then internationalisation will not appear relevant and the uptake of staff development opportunities will remain low. In a research environment it is not always clear who is marginalised as opening up the space between those who research and those who are researched and exploring the dialogue between them, offers an opportunity in which to see the disruption of established assumptions. The awareness of structural issues in this research context reveals how difficult it is for staff to envision agency around internationalisation, without a university strategy to support them.

6.3.3 Internationalism as a Mechanism for Cultural Flexibility

Physiotherapy practice expressed as a negotiation between therapist, the environment and service user generates acts, both in what the therapist does for the service users and what service users do for themselves (or potentially the therapist). In this model of practice, cultural issues diminish, leaving only contexts and responses to those contexts. This position is echoed by Mitchell (1995) when he states that 'there's no such thing as culture', and whilst I empathise with this position to a degree, cultural views have a role. They can usefully be seen to exist, lying within the shared and socially constructed understandings around how one responds to different contexts. However one does need to be careful to include structure when viewing cultured worlds and not locate culture, as it so often has been, as an isolated aspect of social living.

It is within this limited view of the cultural that attempts to internationalise the programme were made. For example there has been an increased recognition of the different meanings attached to functional activities on which so much physiotherapy practice relates. The act of getting in and out of bed or moving from sitting to upright depends on what constitutes a bed, or on what people sit. Is a bed a mattress on the floor, or a hammock? Do people sit on chairs, or on the floor? These differences inevitably involve new thinking about how the person might best be facilitated to move and this requires a combination of tacit and knowledge-skills which are unique to every situation. In the directly clinical modules, movement analysis and rehabilitation thinking has expanded to include case studies and class discussions of multi-culturally inclusive environmental settings, equipment, postures and movements, such as going from kneeling and bowing to standing, as observed by some cultures in forms of prayer. While this embraces difference, it still focusses on cultural, rather than structural, issues and in this way the underlying rationale for practices remain hidden and treatment constructs whilst loosened, continue to be presented in the binary of 'right' and 'wrong', which are unhelpful in addressing approaches in different contexts.

The course situation offers another demonstration of the importance of local practices when considering global issues (Tong & Cheung, 2011). And this is where the research conclusions around cultural dominance in teaching become meaningful in any context, as the challenge for educational programmes working in a cross cultural situation is to generate a programme that is culturally flexible, is suitable for more than one place of working and generates a culturally sensitive practitioner. This challenges physiotherapy education to explain and expose its cultural practices, since these aspects are particularly important to those who enter from outside. They are, of course, difficult to determine, mainly because practitioners are generally unaware of their own cultural understandings and values, which form subconscious views and characteristics of themselves and assumed of others (Friedman & Antal, 2005).

Given the difficulties in addressing all the cultural nuances of practice in this area, a facilitative approach to teaching and learning is therefore to maximise student engagement with their own cultural awareness. This results in reflective opportunities having high importance to allow students to incorporate new thinking into their practice contexts. Thus the MSc course requires tutors and academic advisors capable of promoting and guiding student reflection. The collation of feedback and reflections on learning by students into portfolios (which is already part of the curriculum) could help the link between professional requirements in different locations and assist in generating a body of evidence of students' academic and professional development. Portfolios are a professional requirement for self-regulation and professional auditing is expected of health professionals in many better resourced countries. It supports continuing development awareness for students, even if they ultimately live and work in a location where registration (and professional recognition) is not required at present. Reflecting on this for a moment, it appears that I have here developed a stronger rationale for the professionalism module that I had when I delivered the course. It shows that there was, in fact, some recognition of structural issues, but, at its inception, there was real belief that English physiotherapy was empowering and autonomous, demonstrating some of its limitations.

International issues must be supported by staff who are committed to listening to and also who are culturally respectful of students (Ryan & Viete, 2009). The need for this activity is enhanced at a time when staff are under increasing pressure, time for professional and curriculum development is reduced and reward for undertaking such activities (or penalties for not) are unclear. Not isolating business development from the student experience will ensure that the courses offered are supportive of diversity. This will require an allocation of resources and efforts to learning and teaching, rather than directing strategic attention towards marketing and recruitment. Supporting these changes to involve the timely, integrated and culturally aware input between both course staff and centrally organised services is essential in assisting the student's development in an effective manner (Carroll & Ryan, 2007; Palfreyman & McBride, 2007).

Greater diversity in the classroom, or even outside of the classroom, for both students and tutors would lessen the dominance of English practice and open up discussion around how and why treatments are different. The barriers to participation extend beyond the cultural value placed on English practices: the Masters course on which the participants studied is designed for mainly international students, which only adds to their sense of isolation. Outside the course English nationals are often unwilling to engage with the international students on campus, possibly intimidated by their linguistic capabilities and limited trans-cultural capability which, ironically, restrict opportunities for them to extend these skills while in England.

6.4 Chapter Conclusion

In this chapter I have considered teaching conceptualisations and the innate repression which suffuses the course, a situation that runs directly contrary to the freedom the participants outline themselves in relation to it. There is little evidence to understand the impact of studying overseas in the long term on practitioners. To deem a course neo-imperialist may seem harsh, when tutors clearly show concern for students, but English physiotherapy education is challenged to explain and expose its cultural practices, since these aspects are

particularly important to those who enter from outside. They are, of course, difficult to determine, mainly because practitioners are generally unaware of their own cultural understandings and values, which form subconscious views and characteristics of themselves and assumed of others (Friedman & Antal, 2005).

The results point to a need to disrupt normalised practices, and call for change. Recognising the relevance of cultural sensitivity results in internationalisation being the only response to a globalising world (Haigh, 2002). Greater opportunity to relate to other perspectives would benefit home students as well, as globalisation processes challenge establish world orders.

7 Chapter 7. Summary and Conclusions

In this chapter I summarise the descriptions and conceptualisations that have emerged from this research project. I offer some thoughts on the impact the research journey has had on me and comment on potential impact on issues in practice. Finally I outline the limitations of the research and consider potential future research.

7.1 Introduction

Seeing participants' identifications through an interpretive lens provided by Holland et al. (2001), has allowed me to see the structural issues pertinent to the contexts of therapy and expose the rationale for the practices they described. The two cultural worlds foregrounded in my research are practice and pedagogy and these two aspects have been separated into Chapters Five and Six for the purposes of analysis and discussion. Areas of 'cultural dominance' emerge: first the prominence of English physiotherapy practices over Indian and second the foregrounding of professional physiotherapy practices in professional constructs over service user considerations. The conclusion will address these issues separately and together in relation to a consideration of professional and educational practices. I begin with an analytical summary before outlining the impacts on participants, physiotherapy contexts and me as a researcher. More importantly, I consider solutions to the issues emergent from the research and, at the close of the chapter, I summarise the limitations and highlight potential future research that could lead on from this work.

The multiplicity of identifications that individuals hold in relation to different aspects of their social and professional lives generates a diversity of potential cultural worlds in any group context and these overlap to create a web of interlinked cultural constructions. Whilst they have been discussed separately, they constitute integrated aspects of participants' life constructions. It is important to remember in these discussions the artificiality of differentiating a single cultural perspective from a complex mesh of ideas and identifications

presented by individuals. However, for the purposes of clarity, I will continue to discuss them separately, but now in relation to their impact on the participants, on me as researcher and on contexts in which they occur.

7.2 Analytical Summary

At the start of my research journey I considered physiotherapy as comprising distinct cultural practices. I thought that the research would show me how participants generated an amalgam of practices. I had expected to see a merging of Indian and English constructs where participants would form a new 'third way' of treatments. This would have backed up the findings of much of the literature about cross national learning, which concludes that international students in England forge a new identity through a kind of 'pick and mix' approach to cultural assimilation (Osborne, 1996). However, in this thinking, I had failed to take account of the power relationships at play in this arena.

My research set out to find out how physiotherapists from India change their practice as a consequence of taking an MSc programme delivered in England. Chapter Five focusses on professional identifications and views the structural constraints and power relationships that exert influence on physiotherapy practice in different locations. It shows how power relationships have shaped the nature of those practices in different countries and the fluidity of these power relationships in physiotherapy practice was seen to be manifest in the management of cultural capital. The power discourses existent in therapeutic interactions are present within the levels of activity and passivity, exerted and accepted, between the patient and the physiotherapist.

In the two analysis chapters (Five and Six) I offer varied descriptions and conceptualisations from the data. Chapter Five demonstrates the descriptions of identifications and deduced conceptualisations relating to practice. These reveal both micro and macro power dimensions that shape practice. On a macro scale apparent cultural differences are seen to be embedded in the structural factors that influence treatment. On a smaller scale physiotherapy is perceived to take

place in an environment imbued with power and physiotherapists use their professional skills as sources of power and influence.

Chapter Five exposes the overall impact of participants' adjustment to course learning as a wholesale adoption of English practices. These results settle the debate for this course about assimilation or enculturation from exposure to other countries (Schmitt et al., 2003) (see section 2.6): 'becoming like' is clearly the outcome. The terms 'active' and 'passive' are used to describe physiotherapy approaches and participants suggest that they have developed a more active approach to treatment and are more likely to involve the patient. What the participants actually described, however, was a broadening of available passive techniques with the inclusion of manual therapy techniques, as well as greater levels of specificity when prescribing exercise. I suggested that physiotherapist applied techniques were associated with symbolic meaning, and these reflected the meaning of treatment in different locations. Physiotherapy practice is formed within national and societal contexts and is generated from mixtures of both active and passive forms of treatment. Professional skills are highly symbolic of the meanings ascribed to them and these focus around pain and movement.

'Active' and 'passive' are unsatisfactory terms as descriptions of practice because they absent the role and influence of the patient within treatment and focus purely on the physical performance of practice. They disregard the symbolic and metaphysical aspects of therapy. I present a new 'engagement' model of practice that is applicable across cultures as it transcends national boundaries through the incorporation of an awareness of local and structural influences on working contexts. The model encompasses the various structural and individual power positions of the therapist and the patient during treatment and focusses on the social and relational nature of physiotherapy practice, something little considered in the past. Such a view accepts that physiotherapy can be performed in many different ways, something of a troubling stance for a positivist profession.

Chapter Six addresses the issue of professional dominance that lies behind the positioning of Indian practices as lesser in value and a mechanism by which a professional hierarchy can be extended. The uptake of English physiotherapy constructs has revealed the profound impact of the English mono and hegemonic culture present in the course. The domination of these treatment approaches results in participant perceptions of work place options being reduced rather than expanded, as they recognise the difficulty of applying practice ideals. So, rather than cross national education generating practices characterised by a multiplicity of identifications (as suggested by Grimshaw and Sears [2008]), this programme is characterised by participants' narratives of an essentially monocultural approach to treatments. In such a situation, where only English perspectives are recognised, Indian students could be seen to be oppressed by these 'located' practice constructions. The lack of recognition of other traditions of practice within the course suggests little value and respect for those traditions. The long term outcome of this is unclear, with participants seeking agency through the kind of employment they are willing to take up. However, they also describe internal means of generating agency through engaging in psycho-social (metaphysical) dimensions of practice.

In the research I have reflexively questioned myself about my motivations for undertaking the study, shaping the aims and constructing the understandings of the results in the way that I did. I incorporate my personal history as the background that shapes my views on the world. The methodological approach is flexible, incorporating deductive as well as inductive processes. I present a research journey rather than a methodology partly because of this and also in order to consider my position to the study context, the participants and my contribution to the analysis. As I continue to think about the results I now explore the future potential impact of the research findings on participants, on teaching and learning and on me.

7.3 Impacts

The expression of English hegemony within teaching is revealed by the participants' identifications, from which I perceive inherent inequality within the

course pedagogy. I now suggest potential responses to this through the lens of critical race theory.

7.3.1 Impact on Participants

From a critical race theory perspective the course forms an example of neo-racism. There are gains for the course and for tutors from its intrinsic English-centrism and through the failure to recognise the power relations that underpin and misrepresent English practices (Ladson-Billings & Tate IV, 1995). In other words, even whilst the programme is apparently benign, cultural oppression is, at present, unrecognised by participants and staff alike. The recognition of the privilege that is given to a 'white curriculum' aligns with critical race theory concepts (*ibid*) as well as with the work of other commentators on cross cultural teaching practices (Altbach & Knight, 2007; Edwards & Usher, 2008; Haigh, 2002; Ryan & Viete, 2009; Volet, 2004). So even whilst I am discomforted by my analysis which implies both criticism of the programme on which I worked and my colleagues within it, the analysis resonates with regard to its meanings in the views of others, albeit studying different contexts and different subjects (Delgado & Stefancic, 2012; Gillborn, 2006).

As I developed my understanding of apparent oppression, I summarised my findings and shared them with all the participants. I was puzzled by the lack of response to my communication. It may simply be that their lives have moved on and that this was no longer of interest to them. Alternatively they may not have been sure how to respond, but this is in contrast to some evidence (Ahuja, 2012) that alumni of the programme are able and willing to enter into debate about the role and practices of physiotherapy.

It should not be forgotten that participants describe an internal sense of freedom of thought and increased confidence from taking the course, they may therefore have been reticent to criticise a programme they felt to be beneficial. From a theoretical perspective, however, Ladson-Billings and Tate IV (1995) talk about 'interest conversions' where the wishes of the oppressed and the oppressors converge. This may conceivably be seen in the physiotherapy MSc programme

where the gains for English tutors and institutions may be obvious, but the participants also gain from the hegemony of the course. They acquire cultural capital from having studied in England and this is helpful to practice in a society where a degree from the UK carries status. This, in their own words, also supports the development of their confidence. They desire, and indeed seek, the hegemonic practices which persist and confer status in an unequal world.

The lasting impacts of the programme are, of course, difficult to determine from a short term research project, but the potential sense of alienation and deficiency that the programme's cultural messages contain could have ongoing impacts for practitioners – regardless of where they work. Being exposed to discourses of power and privilege can bring a sense of shame (Sennett & Cobb, 1973; Solorzano, 1997), however these may be latent or difficult to express by participants during the research. The longer term impact of the programme and its teaching, indeed its usefulness in working contexts, would be an obvious source of further study.

7.3.2 Impact on Contexts of Practice and Pedagogy

The replacement of Indian practices with English constructions of working raises issues of applicability and acceptability when practice transfers back to India. The impact of devaluing Indian practices through studying an English Masters appears to narrow, rather than expand, participants' professional opportunities. However, this may not impact negatively on them as working in private practice will enhance their earnings. But their loss to public services, as evidenced by their views towards employment once returning home, will disadvantage some of the world's poorest and most deprived individuals. A lack of structural appreciation facilitates the continuation of a series of inequalities played out in multiple contexts, between patients and therapist, between students and tutors and between India and England.

In taking a critical ethnographic stance at this point, I can attempt to identify and illustrate the processes by which cultural repression occurs and suggest ways to resist it (Madge et al., 2009). This critical stance encourages me to challenge

the supremacy of English physiotherapy culture and the deficit model of practice that is so commonly attributed to Indian health care practitioners in England (Caluya et al., 2011; Le Ha, 2006). It also allows me to suggest ways in which education might be less oppressive in its approach to cultural 'others' (Haigh, 2002). While the course opens out the arena of clinical decision making for the participants, it does so in a relatively confined context, and a more open approach to forms of professional relationship would diversify content. A non-distorted communicative experience would require student and tutor engagement where interaction does not transmit a culturally defined privileged position (Osborne, 1996).

Cultural competency has been discussed in physiotherapy practice by others (Beach et al., 2005) but frequently at a superficial level, for example, in understanding the conventions of another culture. In failing to address systems of power and privilege it does not permit an examination of how institutions reproduce cultural oppression. One only has to look at the attainment of black and minority ethnic students in HE to see some of the impact of this in other outsiders to the education system (Gillborn, 2006). Also important is support for counter storytelling (Solorzano & Yosso, 2002), hearing the stories of the returned professionals, currently silent in the literature. This will emerge as i) students learn more, engage more deeply about context and recognise inherent inequalities and ii) as physiotherapy continues to develop its sense self. These will be supported by the rise of India as an economic power.

The issues exposed in hegemony perhaps reflect a course in 'stasis' whilst its context changes, and rather than supporting students to work in England, now the course needs to offer professional development to therapists who are going to work elsewhere in the world. This transition to recognition of the locatedness of working, is difficult because of the failure of English physiotherapy education to explain its cultural practices, having little awareness of them. A constructionist approach where the practices of others are spoken about and valued would feature in such a programme development and this would require structural and situational awareness and understanding (Stoetzler & Yuval-Davis, 2002). An example of a necessary development could be an exploration

of the claims to autonomy by UK physiotherapy. This can be seen to be influenced differently at different times and places by many factors, including the level of medical involvement, legal and regulatory issues, payment relationships (private or public), relative authority, medical hierarchy and also physiotherapist personal claims on position. Being aware of such structural constraints to UK practice would form an area of understanding lacking from the current curriculum.

These considerations have allowed further research ideas to come to light, which I outline in section 7.5.

7.3.3 Impact on me as Researcher

Ethical issues resound around the justification of the truth claims I make, as well as my capacity and legitimacy to do this as a part of the programme being viewed. My reflexive approach acknowledges my own cultural positioning and the lens through which I examine the cultural views of others (Pillow, 2003). Through my experiences with other cultures in England and overseas I recognise that I am sensitised to see the disadvantage experienced by others. Now, at the close of the project I reflect anew about my choice of Indian participants. At times I have felt guilty for taking part in the 'brain drain' by teaching on this programme and this guilt may have provoked my choice of study. I needed to make sure that the students were 'gaining' from the course. Indeed, they do gain, but perhaps at a cost as yet unexplored and unexplained. There is little I can do about global movements of people or the global shortage of health care workers, but I can help establish a commitment to ethical and respectful student engagement.

In striving for a more equitable MSc course for international students it might be easier to challenge constructs of practice and facilitate analysis of the structural aspects that shape those practices, rather than address the dominantly 'white' curriculum that contains these ideas. In doing this and by exploring a greater diversity of treatment approaches within the curriculum the 'deficit' model expressed towards the different practices of other physiotherapists would be

challenged. This could help the development of insight into the situated knowledge of physiotherapy practice (Lave & Wenger, 1991) as a precursor to viewing the normalising of English practice and might also create some 'bridging capital' for these ideas (Putnam, 2002) allowing them to be more widely accepted and understood.

As I have had an impact on the project, so the project has influenced me. Increasing awareness of structural constraints and the limitations of my agency caused me to reflect on my role in the institution in which I previously worked. Despite my position and identified role, the failure of the university strategy to embrace internationalisation resulted in some tension when trying to develop teaching practices. This, combined with my distance and lack of direct influence in the programme itself, caused an acute sense of discomfort. Ultimately I took a post in another university which has a strategic direction more embracing of all forms of diversity.

Having considered the impact of the research, I now address its limitations in terms of the constructs used to view the results and my performance as researcher and data analyst.

7.4 Limitations of the Research

7.4.1 General Limitations

The cultured world of the programme is generated by the people, the place and the time of its undertaking (see section 2.3). The discussions necessarily focus on the professional world of physiotherapy pedagogy within one specific MSc Physiotherapy programme at one English university in the academic year 2012-2013. The uniqueness of the context of the research raises the issue of how far this culture can be said to be shared. As with all research of this kind, the main stimulus is not to generalise and the issue of how representative the research results are cannot be answered solely in this thesis. No concrete generalisations of the analysis can or will be made. Furthermore, a postmodern take on practice suggests that there is no homogeneous, single culture that

embraces the entirety of therapy practice and so trying to establish one becomes a pointless exercise. Instead the focus tries to maintain the authentic voice of participants and to open, rather than close, discussion around this area of work and practice (Huberman & Miles, 2002). Since grounded theory aims to build theory, whilst I write about 'physiotherapy practice' in Chapter Five I refer to that working construct generated by the course participants, rather than any wider cultural practice claim and look forward to the debate that may be possible as I disseminate my analysis.

Much of my discussion relates to the cultural worlds of physiotherapy practice and in this work I have used ideas and constructs that are apparent in pedagogic discourses (as a social science arena) to generate insight into the health care arena. This is because there is very little written relating to the culture of physiotherapy practice, so it is difficult to compare or add my interpretations of the participants' narratives with those found elsewhere. This is possibly because physiotherapy is still a relatively new profession (see section 1.2) and its dominant research discourse is positivist (Jones et al., 2006). Thus physiotherapy as a profession has yet to demonstrate a comprehensive understanding of itself in the literature. Some theoretical perspectives have been put forward, but there is virtually no research in this area with which to compare it. This is not a weakness of the research *per se*, but it does exist as a limitation to the discussion. Others may be considering these issues. Indeed, since 2014 a web based Critical Physiotherapy Network[24] has been engaging in exactly these kinds of issues but material debated has yet to fully enter the academic arena.

In this context my interpretations are just that, interpretations which I have shared with as much transparency as possible (Wertz et al., 2011). Alternative positions on the narratives are possible and different voices from both researchers and participants might have generated quite different results. How these ideas relate to those of others is something that will emerge outside of

[24] The network is located here: http://criticalphysio.me/2014/07/29/critical-physiotherapy-network-is-born/

this research arena, through the understanding and usefulness of these constructions for others (Onwuegbuzie & Leech, 2007).

In appropriating theory to fit the arena, I have used the concept of cultural capital, a construct of disputed value, given its difficulty of separation with social and economic capital and a consequent lack of specificity. Additionally there is uncertainty relating to the inclusion of skills or competency, or the relationship between cultural and social capital (Lareau & Weininger, 2003). My stance is that qualitative research exists within these indistinct definitions and in over-seeking clarity, distortion can occur. So, whilst I appreciate that cultural capital is a blurry definition of power sources, I think there are grounds to use this overarching principle which relates to 'social influence' to say something about the nature of the work of 'healing' as a source of consideration and dialogue.

I originally set out to interview only Indian students, due to their dominance in the cohort at the project's inception. I could have interviewed anyone that had home experience of another practice construct and potentially garnered similar results. However, I do not regret the single nationality focus as the participants shared similarities in their previous experiences of working in India. With regard to pedagogic practice, this helped crystallise how English tutors position Indian students with their perception of their cultural homogeneity, even whilst recognising that they are all very different.

The research was also limited by what the students were prepared to share with me. I can see that their words were likely influenced by their desire to please me, given the hegemony already outlined. One significant issue that did not emerge at all in discussions was the issue of class or caste. Whilst it might not appear to have a direct relationship to physiotherapy practice, it forms an area of intersectionality with issues related to power and dominance and their combined impact could be considered (Crenshaw 1993). Further consideration of these allied issues would be interesting to explore the micro, rather than the macro dynamics of practice which has been the main focus presented in this script.

Another area of intersectionality is formed from the position of women in Indian society. This has been in focus in recent months, partially as a result of highly publicised rape cases, and one such incident caused the death of a physiotherapy student (BBC, 2012). Feminist perspectives are likely to impact on professional identifications, but they did not emerge explicitly in my research. Further work in this context would be informative, particularly given the feminisation of global health worker movement (Sassen, 2003).

7.4.2 Researcher Limitations

The interviews with participants from the first cohort of students produced fluid and natural discussions, which led to a greater sense of engagement with these participants. As a consequence, I enjoyed these interviews more than with the second cohort of participants. I was glad for the opportunity for a second interview, particularly with the second cohort, which allowed much greater depths of analysis. Establishing a sense of 'presence' was difficult to achieve, even with those known to me. My nervousness at the start of the actual research interviewing meant that I reverted initially to focussing very much around the interview guide that I had produced for the proposal (see Appendix 5) rather than a free flowing conversational style.

On listening back to the discussions I identified some issues relating to my own interview style. Presence has a down side with the immediacy of response. I regret the surprise in my voice when one of the less successful students expressed the desire to undertake a PhD, and the stress I placed on my words in response to an opinion I did not agree with. Although I did not explicitly disagree with the participant, I think they would have been able to sense my thinking. In this way I did not always manage to sustain coherence for participants in terms of my role and responses. Interestingly I think I undertook this better in the second cohort interviews, perhaps as a consequence of more practice and greater personal (emotional) distance. This of course contradicts my earlier argument that knowing participants improves the quality of the data and I accept it as a paradox to practice. Interviews are never easy and each situation raises different challenges.

7.4.3 Limitations in Analysis

As Ahmed (2000) suggests, everyone is a stranger as a consequence of globalisation, increased mobility and urbanisation, therefore standard cultural values cannot be assumed for anyone and reflexive consistency is necessary to avoid portraying such values. My researcher diary supported my reflexivity and self-awareness during this project. For example, I noted that the participants presented ideas from theories explored within the professionalism module that I led, but in my later memos I realised that they were not alone in that. In my analysis I too had drawn extensively on these theories and I also viewed the participant narratives in terms of my module. This is an example of how hard it is as researchers to separate ourselves from the social world we are in (Preston, 1995), notwithstanding the support I received from the supervisory team.

I am also aware of my own complicity in generating the perspectives I have and of my own cultural framework for doing so. Certainly I had to be respectful of the participants' ideas and monitor against self-projection, but I also had to be reflexively aware of why and how I position them and the factors that influence this positioning (Benner, 1984). The analytical approach I adopt involves a merging of approaches using deductive framing of discussion and grounded theory induction. How these approaches influence each other, when I used one approach and not the other is not necessarily clear. The intention here is that I have been sufficiently transparent in my articulation of ideas for these changes in approach to be seen by the reader.

The focus of the research was the impact of the course and questioning was directed towards the meanings to practice that the course had brought. I focussed my analysis on our discussions of this, and so it was inevitable that the cultural position was one generated by an English understanding of practice. Holland et al.'s (2001) framework, through which I have based much of my analysis, is useful in many respects. It permits the combination of structural and individual, cultural and agency aspects, which ultimately produces a single, albeit complex, view. It is, however, still just one way of viewing the arena.

This was the first time that I used NVivo software and initially I was mistrustful of the fracturing of the data likely to occur with mechanical assimilation of codes. On the other hand, I was more fearful of managing the amount and complexity of data that surfaced from the research so I developed skills in using NVivo for analysis partly guided by the supervisory team, partly from attending a course delivered by the faculty and partly self-taught using the Bazeley and Jackson (2013) book. In this way I was able to support analysis with the complexity of data and maximise the breadth of analysis and still assert my researcher's views in these analytic processes. However it is complex software and it could be that inefficiency, particularly in the early stages, limited my analysis and vision of what the data might offer.

Despite its limitations this research has generated a number of ideas for potential future research and I explore these next.

7.5 Future Research Opportunities

The current lack of social science research opens up new avenues of exploration and discovery for the profession now. Giddens (2013) proposes the notion of liquid modernity, and it can be see that this research project has emerged because of cultural provocation of Indian physiotherapists within an English HEI. Physiotherapy practices are challenged by the diversifying presence of Indian physiotherapists as a consequence of globalising processes. In Chapter One I discuss the disruption to the students' views of practice as they enter the UK to study, but their presence disturbs our view of ourselves and offers the potential for reflection on ourselves and our practice. Paradoxically, a clearer view inwards to our professional working will provide a more coherent view outwards to others.

If it is going to grapple with these issues of engagement and hegemony, the physiotherapy profession needs to develop a greater understanding of itself, and in doing so permit a more balanced view of other physiotherapy practices. Recognition of our own structural limitations within practice is part of the way towards an internationalised pedagogy for physiotherapy. Patients and

physiotherapists may not have much room for manoeuvre against structural forces or culturally prescribed patterns of behaviour, but some freedom for negotiation of treatments can potentially occur. There could be a number of ways to explore the notion of sharing symbolic power within practice in order to develop theory in this area. Service user involvement in research will add a necessary dimension to understanding what we do, and participant observation of practice or further interviews about specific treatments could be undertaken to investigate how the relationship is practiced and functions.

Furthermore, working alongside and participating in action research with post-graduates would allow an assessment of how some of the culturally accepted norms of therapy might be challenged, using research to enhance the voice and understanding of Indian patients. Whatever happens, greater insight into the practices and meanings of physiotherapy will only be available as social sciences have greater prominence within the profession, a context recognised for some time (Parry, 1991; Peat, 1981) but without a sufficient critical mass to develop quickly. However there are signs that the discourse of physiotherapy is moving towards greater appreciation of sociological research (Kell & Owen, 2008). The fluidity apparent of this construct is an interesting feature, and it may be that the transfer of power bears some relationship to its function, the act of becoming 'well'. Research in this area has already been undertaken, but exists predominantly in the psychiatric and mental health fields rather than physiotherapeutic (Borg, 2007; Kleinman, 1982; Myers, 2010). Interviewing patients and therapists might show how they engage – or not - with the constructions evident in the treatment arena.

Having recognised a hegemonic curriculum, research to address this is required. Whilst it has been recognised that an effective internationalised curriculum is culturally respectful and more likely to allow the building of practice in a contextualised manner, how this can be done and what the impact of such a curriculum might be remains under-explored. Interviewing tutors to ascertain their beliefs and professional identifications would make an interesting study as would research that directly considers how post graduate therapists actually adapt on return to India, for example re-interviewing the participants of this

research after two or three years (and even again after ten). This could further inform theory around professional identifications and cultured worlds of practice and the longer term impact of the changes to confidence all the participants described. These studies could also be social and/or economic in relation not only to the physiotherapist, but also the community in which they work. Exploring the meaning of practice with Indian service users would be fascinating and represent another dimension of social justice. Narrative and other expressive forms of human communication, including the arts, might be mobilised to explore a community's needs and wants.

Seen in such a way, the treatment arena could be characterised by the social tension existent between the patient and the therapist, relating to their varied expectations and requirements of each other. Therapy then becomes a form of negotiation and the performance of different treatments, as a consequence, results in the retaining or releasing of forms of symbolic power, embodied within the acts of treatments. Its exploration and application to physiotherapy practice would be a fruitful consideration with, for example, an investigation of the subtle changes involved in symbolic power sharing between patients and physiotherapists and how this might affect a patient's recovery or adjustment journey in relation to illness or disability. Having considered the agency of physiotherapists, then addressing agency on the part of the patient and how this affects physical health as a potential characteristic of the 'wellness' process is also pertinent. Regardless of the research stance taken, physiotherapy needs to recognise the importance of the therapeutic relationship and needs to embrace patient involvement as a means of enhancing impact (Higgs et al., 2009). The role and function of the patient can be seen to be under researched in professional literature, given the empirical evidence that suggests that it is patient performed activity that has the most benefit.

7.6 Thesis Conclusion

There remains, as Owen (2014) notes, an absence of professional discourse within physiotherapy literature. Given this lack of writing and research in the area of physiotherapy education, the limited exploration of professional

identifications and the unknown consequences of applying culturally centric knowledge, this research offers several diverse and discrete contributions to knowledge. The first is that the professional identifications of migratory Indian physiotherapists studying in England is better understood. Secondly, the application of a theory of identification to physiotherapy exposes the metaphysical dimensions of its practices, which leads to a recognition of the importance of social positioning in treatment of both patient and therapist through the exertion of different forms of social and cultural capital (including financial). Next, physiotherapy practices can be seen to be highly symbolic and, through their treatment acts, cultural capital is largely retained by the therapist. An exploration of power discourses in practice reaffirms the role of social exchanges in treatment. These can be seen to be performed partly through the mutual expression of confidence. From these professional identifications, a view of structurally mediated practices has been suggested, which forms the bounded, cultural worlds of English and Indian physiotherapy practice, and which challenges the stereotypical views of practice in other countries. Viewing practices in the context of structural constraints and embedded in a power discourse has enabled a unifying view of physiotherapy practice to be generated, irrespective of national context, that functions around the mutual engagement of the therapist and the patient. The limits of agency in physiotherapy practice in different contexts has been exposed. Finally, the subtle nature of cultural oppression in physiotherapy education is uncovered and seen to be little understood. The consequences of this oppression remain hidden.

Exploring physiotherapy interventions from a social perspective, shows that they generate an interface between the patient and the movements, exercises and functional activities that form recovery. Physiotherapy becomes a gateway - a medium - through which patients can engage with, or become motivated to, exercise or to act. Seen in this way physiotherapy is less of a treatment and more of a means of helping people interface with the exercise that they need to do, and where much of the evidence of benefit lies.

I have described my research as a bricolage, looking back I can see more clearly the different methods and methodologies that influenced me at different stages of the research process, from the planning and the performing, to the analysis and final writing up. Phenomenology strongly impacted on my approach to the participants and formed the 'state of mind' I adopted as I planned and undertook the interviews. Constructivist grounded theory played a part in this too, but also and more obviously surfaced in the method I took towards the initial analysis. However later analysis, where I extended my thinking to a consideration of the meanings contained within participant narratives, were strongly influenced by Holland et al. (2001). Particularly their understandings of culture and the restrictions and creativity contained within individual actions. I deductively applied their combined theoretical framework to the interview narratives that acknowledged and engaged with the cultural and power relations between students and staff, physiotherapists and patients. In this way ethnographic perspectives about the culture of practices entered the research arena.

Even now, the location of culture still challenges me. On the one hand I feel as if I have captured something of the Indian cultural world of physiotherapy practice through addressing participants, bound at least in theory, by the same legal and regulatory control. On the other hand, differences in practice have emerged from participants to render this element of control almost irrelevant. The participants discussed English practice more than Indian, and at points I have wondered if I could have interviewed anyone on the course, irrespective of their nationality. But I think doing this would have focussed the project more on the course, the uniting cultural world, which was not the intention. So instead I have settled, in some difficult to define way, on accepting that Indian culture is a phenomenon. By explicitly addressing the evolving relationship between the UK and India and allowing a focus on other ways of being, the project holds true to its original aim of acting with cultural sensitivity. Finally during the act of writing as I considered the power imbalances we (the participants and I) described, and as I sought to address the consequences of the meanings I had seen, then critical race theory, almost as a natural consequence, emerged from the understandings I had gained. This view of critical race theory almost comes full

circle towards the position I started with at the 'transfer' stage of the doctorate. I remember my shock at the racist encounters that graduates described in practice that emerged in the pilot interviews. Only now have I come to a position where I can see and understand not only the prejudiced attitudes and behaviours of others, but also my own. That direct mocking participants described (in the pilot interviews), is no less diminishing for them, (perhaps less so even for its obviousness), than the subtle undermining of which I was part.

This process has changed me, I am more aware of context and construction. Practice has become less clear, there are no longer just the professional narratives of 'clinical reasoning' and 'evidence based practice' but instead, wider contexts for patients and myself and I am more prepared to listen and work with the constructions of others – no matter how at odds these might be with my own, because their constructions have meaning and are part of the context of joint working. I am aware of the changing nature of context, I can see how the NHS is changing, apparently something static and all encompassing, it is now developing in very different ways in different areas as a consequence of devolution and the current Conservative government health care policy (Reynolds & McKee, 2012). At the start of my thesis, most physiotherapists were employed by the NHS, now, whilst it is hard to know how many are, many are employed outside, through the current annexations and partial privatisations of therapy. This makes this research more pertinent, given that professional identifications and practice seem to be more influenced by the healthcare setting rather that national, cultural 'characteristics'.

In my teaching now I seek to explore these and the complex and differing practices and actions that physiotherapy must generate in different situations, rather than prescribing specific action(s). Having developed my sociological understanding of context, my teaching content has become much more based on narratives of uncertainty; what we do in any context depends on multiple aspects of consideration. I see agency for physiotherapists as the process of finding a way through these restrictions, the very act of managing overlapping and competing social constructions.

The impact of negating culture in teaching will only be known or understood in the future as learning continues to be explored. Freire (2008) describes educators as cultural workers and viewing education in this way foregrounds the important role of education in non-oppression and transformative social justice. It does this by offering respectful pedagogies that welcome and are inclusive of diversity. Through the disruption of normative frames, the inclusion of non-dominant frames and the forfeiting of cultural capital then asymmetrical power relations can be addressed, and through the principle of mutual vulnerability (Tummala-Narra, 2009) students and tutors are free to construct their own capabilities and gain the best from their lives (Unterhalter, 2005). An ethical response in this context then becomes less about emancipating the participants or any other student from the dominance of Western practices, but instead challenges the construction of courses that subtly use power and oppressive practices in an educational context.

Understanding this moral perspective on teaching as well as sustaining more of an 'it depends..' approach to teaching content, has resulted in my relationship with students altering. I think in the past I tried to be kindly, but that kindliness was perhaps rooted in mater/paternalism. I like to think that I have developed greater respect for students. Admittedly this is not always easy to sustain as long ingrained lines of thought are quickly and easily reverted to, but I am aware of trying to not project my position onto students and being much more prepared to let them explore their own identities, in their own way. That does not mean I am not critical of them, but that critique is tempered by a greater level of self-questioning regarding my role in their learning.

During the progress of this research the professional context has changed, as it was bound to, given the dynamic nature of practice (Owen, 2014). When I began the research in 2010, the CSP webpages focussed on regulatory issues. They still do, but the Francis Report published in 2013 following failures of care in hospital services influenced a different approach to these, emphasising the moral and personal responsibilities of therapists and so my recognition of individuality (agency) within acts of rehabilitation and care are also echoed within the profession itself.

Despite the lack of professional writing noted at the start of this conclusion, I am nonetheless not alone in sensing the lack of sociological consideration of practice. Others have been on a similar journey of sociological discovery in relation to physiotherapy (Owen, 2014). Sociology is however a broad field and it is interesting to note that what little sociological literature is available relating to physiotherapy takes a Foucauldian perspective (Nichols 2012; Owen, 2014), perhaps as a natural consequence of the dominance of embodied issues like touch and movement to the profession. This literature, takes a single cultural stance towards practice, which is not seen as being in conflict with other cultural approaches. Greater breadth in the perspectives the profession has of itself will be ultimately enriching to its sense of self and to practice development.

In allowing elements of critical race theory (Delgado & Stefancic, 2012) to influence my analysis, I consider myself enabled to speak on behalf of the participants. I can perhaps give more authority to their voices than they might claim for themselves. As I have reflected on my cultural positioning and recognised my own shortcomings in terms of cultural sensitivity, I make criticisms of cultural superiority of the course not to grandstand or to accuse, but to enable others to do the same.

Word count: 61,566

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Appendix 1. Literature Review Process

The literature review contains four distinct topics: the rationale for Indian students studying in England, the different professional practices in different countries, the different teaching approaches to international students and the theory supporting the approach towards identity and culture. This has meant that the literature searching was undertaken in a number of discrete stages, at different times, some even as I was trying to analyse the results, and with the focus emerging sometimes in quite different ways, but always with the intention adding to my understanding of the research arena or the approach taken to explore it. Hart (1998, p. 27) identifies 'ten reasons' to undertake a social science research project and these different reasons underpin the different aspects of the review, as will be seen.

Unlike a systematic literature review where the approach is exhaustive and detailed, a more social science approach was taken, one that searches broadly and selects creatively (Hart, 1998). My general approach was to use very broad search terms and view the resultant literature to gain a perspective on the field and its terminology before going into more detailed searching. Usually my searches raised many thousands of papers, but I read selectively and followed the issues that emerged during my searching, serendipitously. Articles were searched for, either as a consequence of issues raised or as literature referenced. This free flowing literature finding relates to the requirements of an interpretive research project, where clear decisions are not always possible and the judgement necessary to decide on what literature is relevant to the project chimes with that required to make sense of the data.

The first two aspects of the review, the rationale for Indian students studying in England and the different professional practices in different countries were important for me to develop my understanding of the context of the research. And both (to an extent) were undertaken as part of my first assignment of the cohort phase of the Doctorate in Education programme. Initially a very wide university 'library search', was undertaken starting with search terms like 'profession' and 'physiotherapy'. This yielded sufficient for the first assignment, but very little in relation to Indian practice and a complication for this literature review is that due to the relatively low autonomy of physiotherapy in India and

low web penetration within aspects of Indian society, much practice literature remains unwritten or unavailable outside of India (Castells, 2011). So, to support the ideas related to practice in India for the 'scholarly' review I also draw on my work experiences, shaped by a two-week funded sabbatical in Mangalore at the Father Muller College of Physiotherapy in May 2012 (see section 3.4, p. 85). The net conclusions are 'informed', but in diverse ways including experiential and oral, as well as written, information.

The literature review of different teaching approaches taken to international students, was initially undertaken as part of the literature review for the third assignment of the cohort phase of the course. I used various words like international education, international students and intercultural education/ teaching/ learning/ study. The terms transnational, transcultural and mixed culture were all used, although the predominant term exposed was 'transcultural'. This has 'solidified' in the last 10 years or so to mean the educational experience of the cultural 'other' within another, whilst transnational education generally refers to the export of an internationally hegemonic culture, for example when UK HEIs have campuses in China and India, and as such relates more to geographical location. This original search realised a great deal around school and college education and so further filters were applied to focus on HEIs.

Following exploration of this backdrop to transcultural education I narrowed and formalised the search terms in order to generate specific information relating to international students from poorer to wealthier GDP nations, finding material with a determinedly cultural perspective regarding how the student learning was viewed. Social science databases (for example ERIC) were employed using the search terms international student AND/ OR sojourner AND Higher Education AND ethnography (+ truncations). From 70 articles the following were discarded: literature relating to students travelling out rather than in, the focus on teaching rather than students, university policy, irrelevant literature in 'international' journal titles and that relating to schools or theory, or activism, conference proceedings, technology or comment. The remainder (approximately 30) were read and considerations on these form the bulk of this section although inclusion into chapter 2 has necessitated some condensing. Some of the information in this aspect of the literature review also fed into my

understanding of the first part of the review, relating to the rationale for Indian students to study in the UK and the examples of approaches detailed in the literature here enabled me to relate theory to practice through recognition of the main methodological approaches, and through this recognise the significance of the issues I was studying.

The final aspect of the literature review relating to the theory supporting the approach towards identity and culture was formed from a presentation undertaken as part of preparation for the ED 1 stage, where an overview of 'identity' was shared with the cohort. Through the general reading around 'identity' I found Holland, Skinner, Lachicotte and Cain's book 'Identity and Agency in Cultural Worlds' (2001) and have used this as a pivotal source of understanding the concepts of 'identifications' and 'cultural worlds' central to my research. They offer a mechanism by which research can be done that is both realistic and constructive and it is this perspective that I have used to view my results. Here there is not so much a literature review as an explanation of terms. The limitations of presentation resulted in only this offer of an outline and rationale for the project.

It would be true to say that the results have further shaped the nature of the literature review, acting to influence what was included and what was not, with some areas added during the research analysis stage rather than prior to it commencing. This occurred in two key areas relating to the cultural capital and some of the practice techniques discussed in the interviews. Prior to the research work undertaken I explored the political, environmental and, to an extent, the social structural issues, but failed to fully explore these latter aspects fully. This deficit became apparent during the analysis where, in discussing power discourses in physiotherapy practice, I was not able to fully explore the social status of physiotherapists clearly emergent in the narratives. Initially I described this influence as the power of 'healing' and when researching what this might be thought of by others, I came across Bourdieu's theory of cultural capital, which encapsulated my concept ideas well and contained a strong link with the theories I was already incorporating regarding identifications and cultural worlds (Holland et al., 2001). I realise that coming to a concept post hoc to the research and incorporating it is not a recommended approach and it

potentially remains a weakness in this project particularly in view of the general weakness of the construct.

Another example of post analysis literature finding related to the discussion about electrotherapy and manual therapy. Ideas relating to this emerged very clearly and strongly in the interview data and so the literature needed to address these practices which became included in a section on divergent practices and related to structural issues. I have fewer concerns about this though, since some shaping of the background literature review towards the most pertinent information will be necessary in a situation where one is open to the newness of the data.

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Appendix 2. Ethical Permission

Sheffield Hallam University

Our Ref AM/SW/5-2012EdD

Hazel Horobin
Room K201
38 Collegiate Crescent
Collegiate Campus

INTERNAL POST

Dear Ms Horobin

Request for Ethical Approval of Research Project

Your research project entitled "**Exploring Indian physiotherapist's professional identity as they experience UK post graduate study**" has been submitted for ethical review to the Faculty's rapporteurs and I am pleased to confirm that they have approved your project.

I wish you every success with your research project.

Yours sincerely

Ann Macaskill

Professor A Macaskill
Chair
Faculty Research Ethics Committee

Office address :
Business Support Team
Faculty of Development & Society
Sheffield Hallam University
Unit 4, Sheffield Science Park
Howard Street, Sheffield, S1 1WB
Tel: 0114-225 3308
E-mail: DS-ResearchEthics@shu.ac.uk

Appendix 3. Requests for Interview

First Invitation Email Text

Dear Dissertation Students,

I hope this finds you well.

I am inviting you to participate in a research project that I am undertaking as part of a doctorate entitled: **'Exploring Indian physiotherapist's professional identity as they experience UK post graduate study'**[25]. The purpose of this research is to explore how Indian therapists respond to, and use, the learning undertaken at X University.

If you consider yourself to be Indian - then you are a possible participant, because you are someone undertaking the MSc. Physiotherapy programme and you may be able to provide me with some information that could help me gain useful insights into this issue. I would like to speak to about 5 people from your cohort. Your participation in the study will be a minimum of two, hour long interviews undertaken at the start and at the end of your dissertation project. Each interview will be followed by a series of checking exercises to make sure I get your ideas right. If you do not want to volunteer for this that is absolutely fine, but I think you would have some very interesting things to say about the programme and the meaning of it for you in what you do as a physiotherapist. If you are interested in taking part, let me know and I'll send you some more information.

If you have any questions or concerns about this request, please feel free to contact me, by email *address redacted* or on phone number *telephone number redacted*. My study supervisor, Dr. Mark Boylan, can be contacted at *email address redacted*, if you would like to speak to someone independently.

See what you think and let me know. If I don't hear from you in a week, I'll take that as a 'no' from you, but either way, thanks for your time, with all good wishes,

Hazel

[25] Note the change of project title that occurred during the research, however whilst this happened it does not generate ethical issues for the participants.

Second Invitation Email Text

Dear Student Name,

I hope this finds you well and that your dissertation is progressing well.

I am inviting you to undertake the second interview part of the research project that I'm undertaking entitled: **Exploring Indian physiotherapist's professional identity as they experience UK post graduate study**

Your participation in the study will be a minimum of an hour long interview. If you do not want to volunteer again for this, that is absolutely fine, but I think you would have some very interesting things to say about the programme and the meaning of it for you in what you do as a physiotherapist.

If you have any questions or concerns about this request, please feel free to contact me, by email *email address redacted* or on phone number *telephone number redacted*. My study supervisor Dr. Mark Boylan can be contacted at *email address redacted*, if you would like to speak to someone independently.

See what you think and let me know. If I don't hear from you in a week, I'll take that as a 'no', but either way, thanks for your time, with all good wishes,

Hazel

Appendix 4. Informed Consent Document

INFORMED CONSENT

TITLE: **Exploring Indian physiotherapist's professional identity as they experience UK post graduate study**

RESEARCHER: Hazel Horobin

PHONE: *telephone numbers redacted*

WHAT IS THE PURPOSE OF THIS STUDY?

You are invited to participate in a research study about how Indian physiotherapists change how they think about their professional practice as a result of post graduate study at *X University* in the UK.

HOW LONG WILL I BE IN THIS STUDY?

Your participation in the study will be for a minimum of two, face-to-face interviews undertaken as you start your dissertation and then again as you complete it. The interviews will last for approximately 30 to 60 minutes up to a maximum of 90 minutes. You will have the opportunity to see the transcripts and comment on these if you wish.

WHAT WILL HAPPEN DURING THIS STUDY?

Your participation in the study will be as follows:

1. We will agree a meeting time and place by email. Then during our first meeting in a private room at *X University* I will explain the study and you will be given a chance to ask any questions that you may have. Once you are satisfied that you understand the study and your role in it, you will be requested to sign this informed consent document. After signing the document, I will ask you about what you want out of your work, what matters to you in practice and what you want for the future. I will also ask about how you feel you've changed as a result of the course and the ways you see the work that you do as a physiotherapist. The interview will be audio-recorded and later transcribed word for word but additionally I might use any of our communication to inform my analysis.
2. Once transcribed I will contact you again by email so you have an opportunity to clarify some of the ideas that arise from the interviews.
3. I will contact you again by email towards the end of your study time at *X University*, to undertake another interview when I will interview you again.

If you wish more information regarding the analysis you can contact me at any time up to September 2014 for this and a copy of the final dissertation will be available to you once it is completed.

In the course of this study, to protect your identity, you will be assigned a pretend name or 'pseudonym' (you can choose this) and this will be used instead of your name in the interview transcripts and in all analysis and subsequent written reports. Anything you say that has the potential to reveal who you are or who anyone else is, will be changed in any reports to conceal your and their identity.

If at any time during this study you feel uncomfortable or do not want to answer any of the questions posed to you by me, you are free to decline. You will not be penalized in any way

because of your refusal to participate in any of the interviews or to answer any of the questions. Be assured I will not mind or be offended.

WHAT ARE THE RISKS OF THE STUDY?

There is a slight risk that as you examine your life, it might make you feel unsure about how stable your identity is right now. Also, talking about what your hopes and aspirations are may lead you to share details of intimate aspects of your life that are not meant to be shared with people who are not close to you. For this reason you can withdraw any aspects of the interviews you do not wish to be included in the analysis for up to two weeks after either of the interviews. After this time the analysis will have progressed to the point where it will be difficult to remove your thinking from the summary. The risks described above are not great, but none the less, if you experience anxiety you may stop participating in the study at any time by indicating to me that you do not wish to continue with the interview, or by refusing to answer any questions if you do not feel comfortable doing so. If you would like to talk to someone about your feelings regarding this study, you are encouraged to contact me contactable on *email address redacted*. Alternatively you can contact my supervisor Dr Mark Boylan *email address redacted* or *telephone number redacted*

WHAT ARE THE BENEFITS OF THIS STUDY?

You may benefit personally from participation in this study by exploring ways of thinking about how you practice and choose to represent yourself through how you think about daily activities. You may also gain some insight into conducting qualitative research projects. Other than gaining such insights, there will be no other benefits to you personally.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY? WILL I BE PAID?

You will not have any costs other than time commitment for being in this research study. You will not be paid for being in this research study.

WHO IS FUNDING THE STUDY?

Neither I nor *X University* are receiving payments from other agencies, organizations, or companies to conduct this research study.

CONFIDENTIALITY

The records and information that is obtained in connection with this study and that can be identified with you will be kept private and confidential, only disclosed with your permission and to the extent permitted by law. My study record may be reviewed by *X University* governance systems. However, you will not be identifiable in any report about this study that might be published. If I need to discuss what you have said with my supervisor or other academic staff, you will not be mentioned by name. The interviews with me will be audio-taped. You have the right to review/edit the tapes if you wish. Only I will have access to the audio-recordings, and they will be erased as soon as the study has been evaluated, January 2016 at the latest. To protect the identity of non-participants, any reference to them during the interviews will be by fictional names.

IS THIS STUDY VOLUNTARY?

Your participation is entirely voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your current or future relations with the *X University*. If you decide to leave the study early, I ask that you contact me and let me know as soon as you have decided. You are not obliged to disclose the reasons for your withdrawal, and I will not contact you again on this matter. You will also be

informed by me of any significant new findings that develop during the study which may influence your willingness to continue to participate in the study.

CONTACTS AND QUESTIONS
You may ask any questions you have at any time. My contact details are:
Hazel Horobin, I may be reached at + 0044 (0) *telephone number redacted* during the day or *telephone number redacted* after hours. This is my work mobile. My address is:
Address redacted
You may call these numbers or write to this address if you have questions, concerns, or complaints about the research.

If you have questions regarding your rights as a research subject, you may contact Dr Mark Boylan who will represent SHU Faculty of Development and Society Ethical Review Board. It is best to contact him by email initially. The Ethical Review Board is a group of people at SHU that review all research projects to protect participant's rights and welfare. This study has been accepted by them, but you may also call the number below to tell the university about any problems, complaints, or concerns you have about this research study. You may also call this number if you cannot reach me, or you wish to talk with someone who is independent of me.

I give consent to be audiotaped during this study:

Please initial: ____ Yes ____ No

I give consent for my quotes to be used in the research; however I <u>will not</u> be identified.

Please initial: ____ Yes ____ No

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Subjects Name: _____

_____ _____
Signature of Subject Date

Statement of Hazel Horobin (Researcher) Who Obtained Consent

I have discussed the above study with the subject or, where appropriate with the subject's legally authorized representative. It is my opinion that the subject adequately understands the risks, benefits, and procedures involved with participation in this research study.

_____ _____
Hazel Horobin Signature Date

Faculty of Development and Society
Sheffield Hallam University
Faculty of Development and Society
Graduate School

Research Support Team Unit 9 Science Park
City Campus
Telephone: 0114 2253671
www.shu.ac.uk

Appendix 5. Interview Guide

Interview Guide - First Interview

What did you want to learn from your studies in the UK? What do you feel that you learnt from your studies? How do you apply this to practice?

How do you feel your practice has changed over time?

Has how you think about physiotherapy changed? What does it mean to you to be a physiotherapist?

What kind of physiotherapist are you? What kind of physiotherapists are there?

What makes a good physiotherapist?

What does it mean to you to be a physiotherapist with a Masters degree from the UK? What does this give you that you didn't have before?

How is physiotherapy in the UK different from India? On what do you base this thinking?

What is important to you as you work now?

What do you still wish for in terms of your practice? What do you hope for?

Re-worked First Interview (for the Second Cohort)

I realised that as I began to interview the subjects that issues around meaning and being were important and so I included the following questions for the second cohort:

What does it mean to you to be a physiotherapist? Why did you want to be a physiotherapist?

What does it mean to you to have done your PG study in the UK?

How do you talk about this with your friends and family?

Interview Guide – Second Interview

What do you feel that you have learnt from your dissertation project? How do you apply this to practice? Did you learn what you wanted to, how has your thinking about practice changed as a result of doing your dissertation?

What makes for a good dissertation?

How do you feel your practice has changed over time now?

Has how you think about physiotherapy changed? What does it mean to you to be a physiotherapist?

What does it mean to you to be a physiotherapist with a Masters degree from the UK? What does this give you that you didn't have before? What do you think you will do with this now?

What is important to you as you work now? What do you want to do or achieve now?

Appendix 6. Examples of Approaches to Text Analysis

The following example, from Kevin's first interview, illustrates my various interpretations as the dialogue extends and the coding builds:

> '*..when I was coming to UK I was thinking of getting more practical knowledge*,'

I related this phrase to his academic expectations of what he thought he would gain from the course.

> *'..when I was coming to UK I was thinking of getting more practical knowledge more, er, ar, I will get the chance to touch a patient, I will get the chance to, sort of, treat a patient,'*

This establishes the importance of touching real patients in order to develop the practical skills he seeks from the programme.

> '*..when I was coming to UK I was thinking of getting more practical knowledge more, er, ar, I will get the chance to touch a patient, I will get the chance to, sort of, treat a patient, so that I, I would be confident enough to apply it, in my setting*,'

Confidence is an aspect of care that is important in professional working and practical experience with patients is considered to help develop this confidence

> *'when I was coming to UK I was thinking of getting more practical knowledge more, er, ar, I will get the chance to touch a patient, I will get the chance to, sort of, treat a patient, so that I, I would be confident enough to apply it, in my setting, but I didn't get that chance,*'

This reflects disappointment in not having contact with patients and was perceived as limiting the development of professional practice skills.

> *'when I was coming to UK I was thinking of getting more practical knowledge more, er, ar, I will get the chance to touch a patient, I will get the chance to, sort of, treat a patient, so that I, I would be confident enough to apply it, in my setting, but I didn't get that chance, but, still I applied to my colleagues'.*

He was only able to practice on colleagues – a small compensation and a comment on how the course functions:

> '*when I was coming to UK I was thinking of getting more practical knowledge more, er, ar, I will get the chance to touch a patient, I will get the chance to, sort of, treat a patient, so that I, I would be confident enough to apply it, in my setting, but I didn't get that chance, but, still I applied to my colleagues, so that does boost your confidence, because you are applying the technique on someone*,'

Kevin recognised that, although his practical experience was limited, it did actually have the impact of enhancing confidence. The ideas represented above form a kind of journey around initial expectations, disappointment and establishment of other practices that are ultimately valued.

On the other hand some text contained narratives that were stories in themselves and defied fracture:

> *'I remember this patient which was a case of low back pain, and er the standard protocol as such would be, to er, er ask the patient to wait for about 10 minutes first, then er, use some of the um short wave er machines on the patient and then treat some other patients in the meanwhile, and come back and do some extension exercises, however, er firstly I didn't know how to operate the machines, so I didn't use the electrotherapy (laughs) .. was with the, the, the graduate so I re - first talked her through what my approach would be and I just, er, I , I, I went ahead and I spoke to the patient and er there wasn't any electrotherapy involved at all, so I was first, questioned and it was like if the head of department gets to know that you haven't used the device, you're going to be in trouble and I was like well I don't know how to use it and even if you do it you, you asked me to tell the patient or to, to, to show you something that I would do in the UK, so that is where I am and I'm, I'm showing you something different, so in the end I think the, the patient, was, um was, was literate ..and he could understand what I was saying and he understood how the, the condition had an overall im-impact on his life and his lifestyle and the kind of um information and advice I gave him did make sense to him. However.. he had been coming to the department for electrotherapy, he wasn't really happy with the kind of advice and just the advice that I gave him and some exercises so in the end, of course the, the graduate had to take over because she knew how to operate the machine and that's what calmed the patient down and made him feel, yes, he'd received some physiotherapy but just my talking did not really help, and even hands on is not as er ful-fulfilling and satisfying for the patient in India,'* SB 1

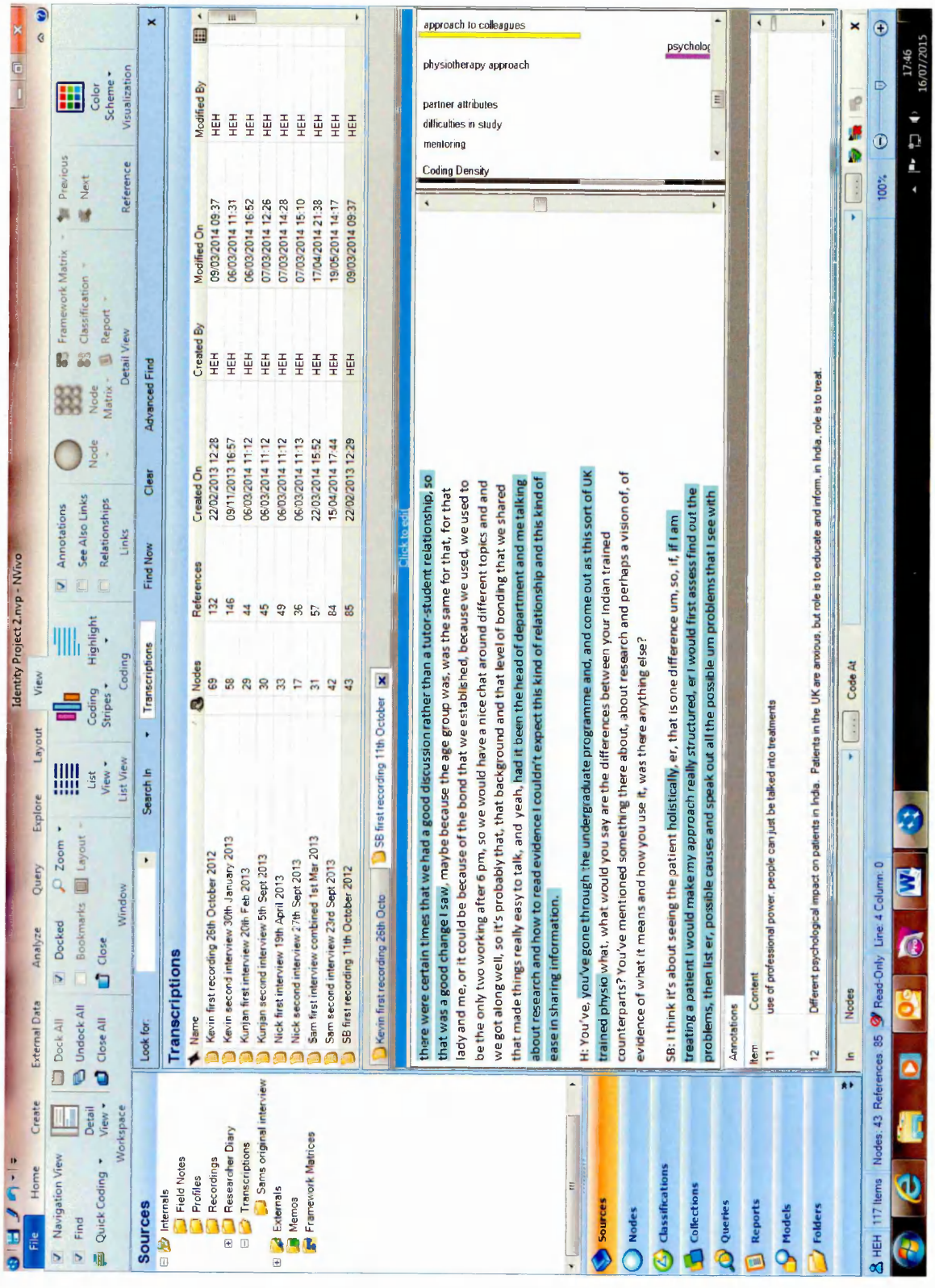
I coded this text as a whole as an example of the 'difficulty of transfer of approach from one country to another' but wrote 3 memos associated with it around the use of electrotherapy in India and the identifications of practice it represents, the desires and responses of the patient and the lack of transfer of English approaches.

In these different ways I tried to explore the text in all the ways that occurred to me, going over the text numerous times, in order to register all the ideas

possible for a given piece of text. Where necessary, I noted issues contained within narratives to incorporate all emergent ideas. In practice this started as very short sections of script, but these gradually extended as larger chunks of text as ideas built and relationships emerged.

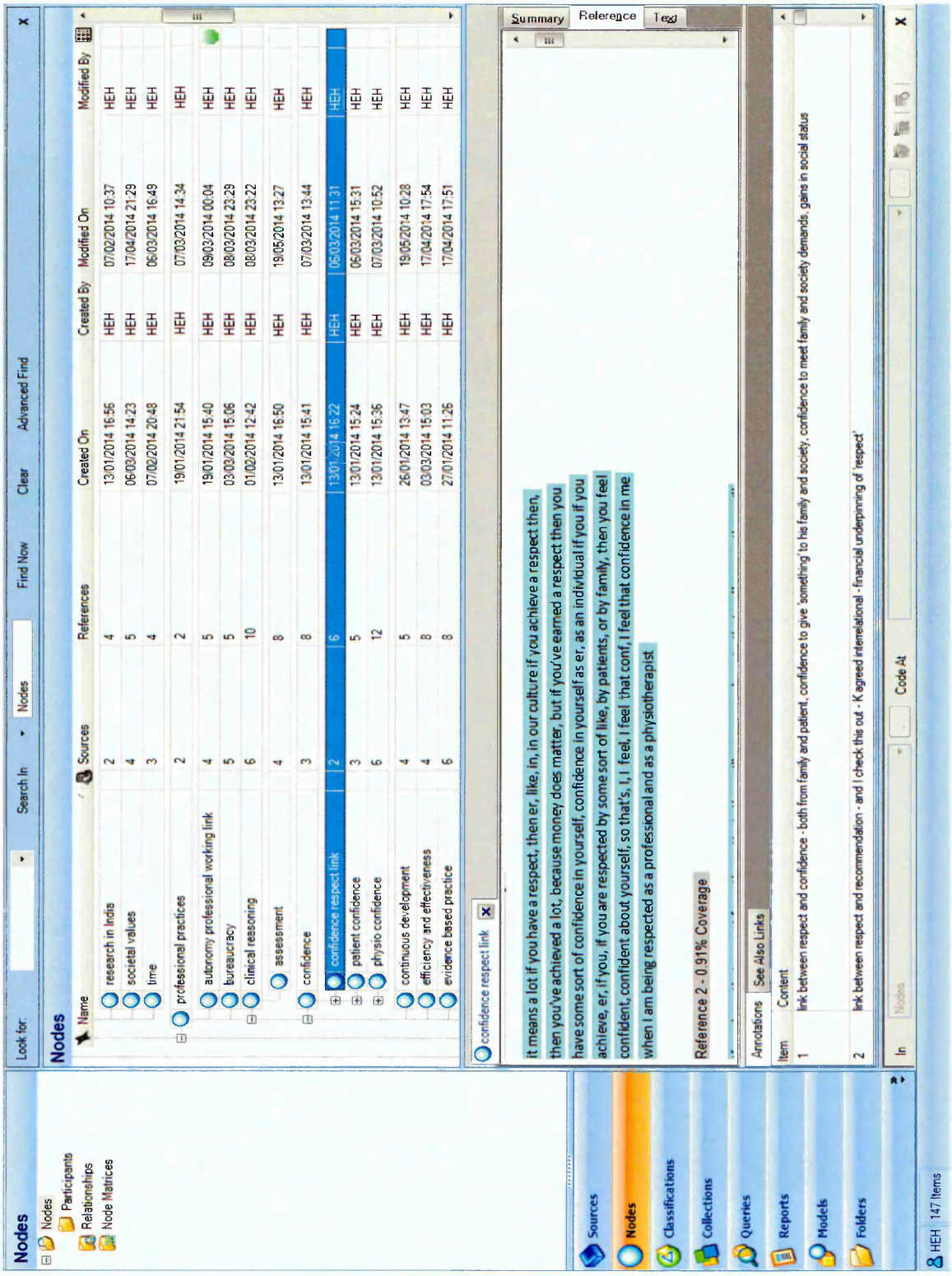
Appendix 7. Coding and Analysing in NVivo

Screen shot 1.



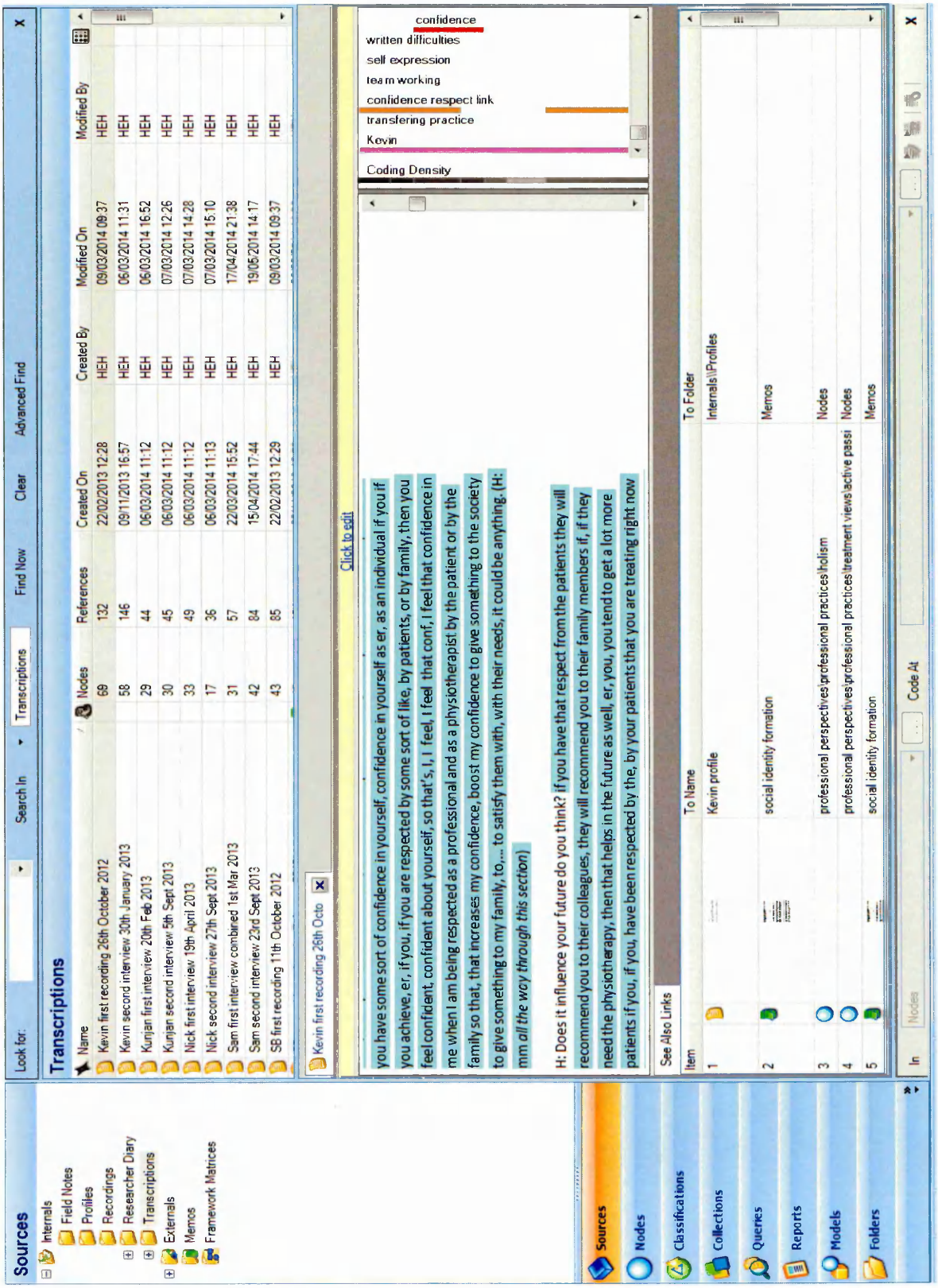
This screen shot shows the initial phase of data analysis, where transcriptions were coded and annotations were made in relation to the codes and thoughts generated. It shows the whole screen.

Screen shot 2.



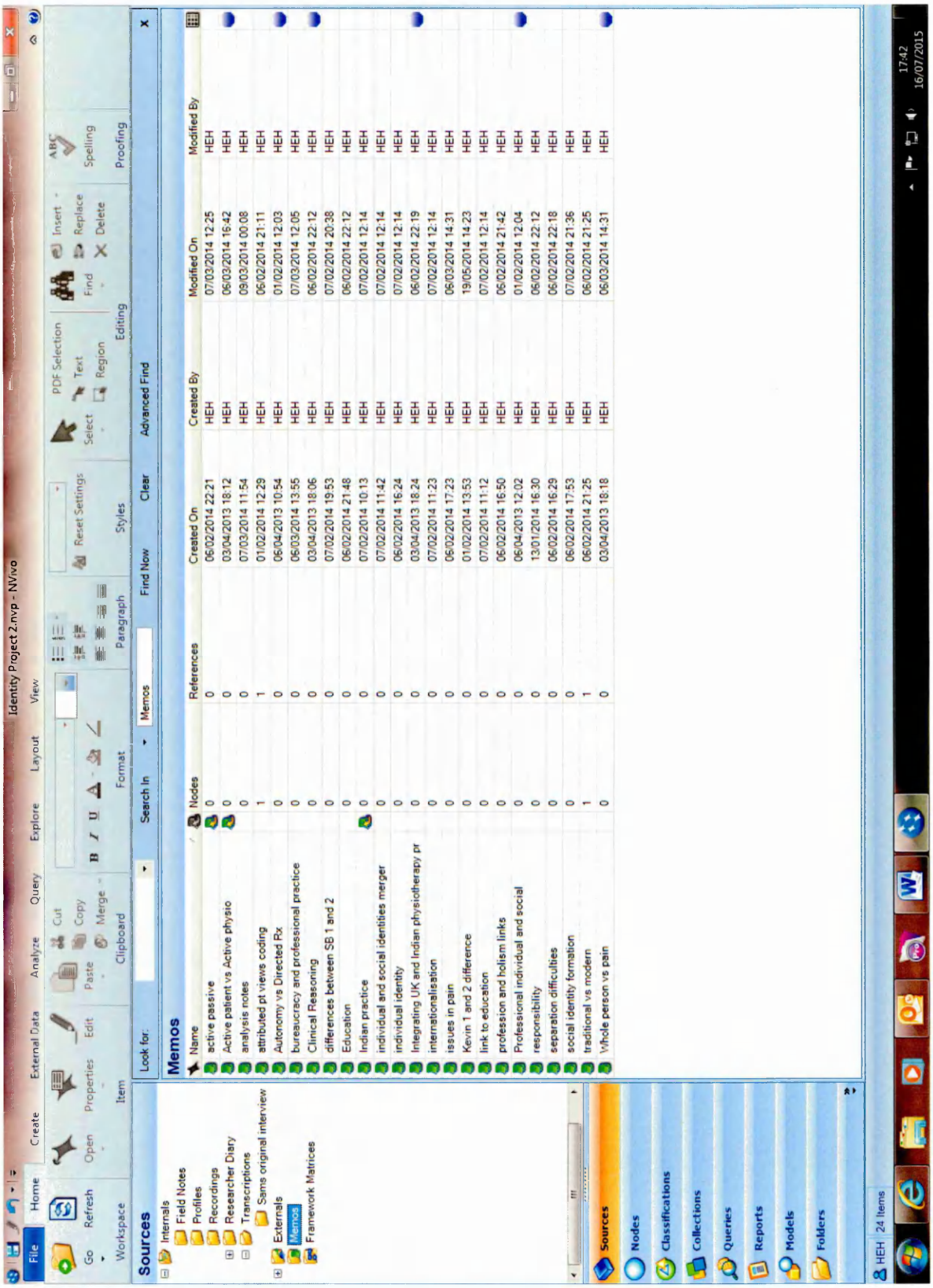
As coding progressed a list of more than 160 codes emerged, some of which can be seen in the screen shot here. In addition to the code, the actual text and related annotations are visible. The screen has been cropped to show just the NVivo elements.

Screen shot 3.



Here material can be seen to be related by 'see also' links shown at the bottom of the screen shot.

Screen shot 4.



As coding and annotating progressed, ideas emerged that I registered as memos. These were a means of locating my analytical thinking in with the text that had generated the ideas.